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INDEX

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INDEX

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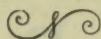


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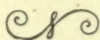
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THE CANADIAN NURSE

Index to Volume 46

January — December 1950

The material in this Index is arranged under subjects, authors, and titles. Titles are given in full with the author's name.

The following abbreviations appear in this Index:

C.N.A.	— Canadian Nurses' Association
(ed.)	— editorial
por.	— portrait
R.N.A.B.C.	— Registered Nurses' Association of British Columbia
(rev.)	— book review
R.C.N.	— Royal Canadian Navy
U.B.C.	— University of British Columbia
V.O.N.	— Victorian Order of Nurses
WHO	— World Health Organization

The page numbers included in each issue of Volume 46 are shown below:

January.....	pp. 1-80	July.....	pp. 513-600
February.....	pp. 81-160	August.....	pp. 601-680
March.....	pp. 161-248	September.....	pp. 681-776
April.....	pp. 249-336	October.....	pp. 777-856
May.....	pp. 337-424	November.....	pp. 857-936
June.....	pp. 425-512	December.....	pp. 937-1024

A

ACCREDITATION and evaluation:

- of educational programs in nursing (Street), 187
- Evaluation of schools of nursing, 112
- Evaluation of schools of nursing (Lefebvre), 278
- Professional, 991
- of schools of nursing, 133
- Who is responsible (MacLeod), 460
- Work conference on (Claire), 819
- ACCREDITATION of educational programs in nursing (Street), 187
- ACUTE anterior poliomyelitis (McCarthy), 793
- ADAMS, Carol M. (rev.), 916
- ADAMSON, J. D. (Beamish, Griffin)
- Hypertension, 449
- ADULT education:
 - Group dynamics, 304
 - Pamphlets on, 305
- ADVENTURE in nursing (MacLaren, McDowell), 100
- AGENCY's part in planning a student program (Weatherhead), 294
- AGNEW, Dr. Harvey, resigns, 67
- AIDES dans l'équipe en nursing (Lindblad, Struve), 554, 649
- AIDS to male genito-urinary nursing (Sayer), (rev.), 64
- AIKIN, Ruth Catherine & por., 903
- AIMS of professional education (Henderson), 638

AINSWORTH, Joan

Ambulance duty, 285

AITKENHEAD, Clara (rev.), 915

ALBERTA:

- Annual meeting in (Van Dusen), 567
- Appointments, transfers, resignations, 152, 406, 619, 921
- Echoes from the foothills (Clark), (ed.), 93
- Journal subscriptions, 356
- New year greetings (Van Dusen), (ed.), 11
- News notes, 71, 227, 324, 407, 488, 670, 926
- Provincial association highlights, 386

ALEXANDER, Edythe L.

Operating room technique (rev.), 62

ALLEN, F. Moyra (rev.), 751

ALTSCHULE, Mark D.

Physiology in diseases of the heart and lungs (rev.), 321

AMBULANCE duty (Ainsworth), 285

ANDERSON, M. Doris

Mother breast feeds her baby, 972

ANDREWS, Edna E., 462

ANEMIA:

Nutritional (Sister Clare Marie), 575

ANESTHESIA:

Anesthesia (Wishart), 95

Pre-anesthetic preparation (Barnett), 96

ANESTHESIA (Wishart), 95

ANGINA pectoris signs, 65

ANILINE dye poisoning of babies (Howes), 194

ANNE of the Sacred Heart, Sister (rev.), 665

APERÇU sur le service social à l'assistance maternelle (Verret), 985

- APPRAISAL of nursing care, 990
 ARCHIBALD, Muriel (rev.), 62, (por.), 978
 Statistical report, C.N.A., 351
 ARCHIVES:
 Committee on (MacLennan, Forest), 382
 ARRANGEMENTS committee (Wyness), 378
 ARTHRITIS:
 Chronic (Robinson), 525
 Problems in nursing arthritics (Jermyn), 530
 ASSURANCES sociales (Giroux), 204
 AST, Helen
 Battle against leprosy, 547
 AUXILIARY nursing groups:
 in hospitals (King), 558
 Sub-committee on auxiliary workers, 135
 AUXILIARY workers in hospitals (King), 558

B

- BAKER, Grace H.
 I had a dream (poem), 570
 BALLANTINE, Dorothy F., 462
 BANTI's disease (Wilms), 56
 BARNES, Josephine
 Towards easier childbirth, 964
 BARNETT, E.
 Pre-anesthetic preparation, 96
 BARR, Doris Martha & por., 737
 BARRATT, Winifred (rev.), 664
 BARRETT, Ethel M. & por., 738
 BATTLE against leprosy (Ast), 547
 BEAMISH, R. E. (Adamson, Griffin)
 Hypertension, 449
 BEITH, Esther Mary & por., 906
 BELL, Louise P.
 Care of His Majesty, 981
 BENNETT, Arnold (Oakes)
 Materia medica for nurses (rev.), 998
 BERMUDA:
 Ambulance duty (Ainsworth), 285
 News notes, 235, 762
 BERNADETTE, Sister M. (rev.), 226
 BERRY, Mary Ogilvie (rev.), 62
 BEYER, Bianca
 Construction of hospitals, 107
 BILE acids, 118
 BIRCH, Bertha & por., 48
 BIRTH-RATE increase, 102
 BLACK, A. Isobel
 Student nurse work conference, 826
 BLACK, Isabel (rev.), 844
 BLACK, William G.
 Counselling for nurses, 818
 BLACKWOOD, Mary (rev.), 662
 BLAKISTON'S *new Gould medical dictionary*
 (Jones, Hoerr, Osol), (rev.), 63
 BLANCK, Fred C. (Wooster)
 Nutritional data (rev.), 405
 BLOOD conditions:
 Banti's disease (Wilms), 56
 Hemolytic disease (Kelley), 995
 Methemoglobinemia (MacLachlan), 140
 BLOOD pressure:
 Hypertension (Beamish, Adamson, Griffin), 449
 Nursing the hypertensive (Sigmundson, Einarson), 455
 Public health nurse's role with the hypertensive (Petursson), 458
 BOND, Aileen, 473

- BOURBONNAIS, Berthe & por., 563
 BOURNE, Hilary D.
 Breast feeding, 969
 BOWDEN, Dorothy (rev.), 405
 BOWERMAN, Valerie (West, Chard)
 Handbook for industrial nurses (rev.), 919
 BRACKENRIDGE, Eva (rev.), 319
 BRADLEY, Leonard O., 342
 BRADY, Leo (Kurtz, McLaughlin)
 Essentials of gynecology (rev.), 916
 BREAK with the past (Burnette), 836
 BREAST feeding (Bourne), 969
 BRIDGE, Edward M.
 Epilepsy and convulsive disorders in children (rev.), 581
 BRITISH Columbia:
 British Columbia (Ireland), 261
 Chest survey clinics, 1002
 Fact sheet on labor relations, 60
 Interim report, 132
 Metropolitan health committee, Vancouver, 923
 New year greetings (Wright), (ed.), 12
 News notes, 71, 152, 227, 324, 408, 489, 587, 671, 756, 847, 926, 1003
 Nursing students' award, 580
 Provincial association highlights, 386
 Student nurses' association of (Juleff), 402
 Vancouver by the sea (Wyness), 439
 Welcome to all (Columkille), (ed.), 259
 BRITISH Columbia (Ireland), 261
 BROADFOOT, Ina
 Labor relations committee, 374
 BROGAN, Mildred & por., 47
 BROWN, Amy F.
 Clinical instruction (rev.), 224
 BROWN, B. C. (England, Hauch, Lewis)
 Study of congenital heart disease by cardiac catheterization, 548
 BROWN, Ruth B. (Gibson)
 Learning by seeing, 660
 BROWNE, Jean Elizabeth & por., 191
 BUCHLER, Walter
 Parkinson's disease (rev.), 998
 BUILDING maturity (Schram), 881
 BURNETTE, N. L.
 Break with the past, 836

C

- CALDERWOOD, Carmelita (Funsten)
 Orthopedic nursing (rev.), 664
 CALVARY, Sister Mary of (rev.), 998
 CALVEY, Sister M. Eucharista (Preher)
 Sociology with social problems applied to nursing (rev.), 997
 CAMPBELL, Agnes
 Tuberculosis prevention, 67
 CAMPBELL, Margaret Murray & por., 903
 CAMPING for crippled children (Ross), 543
 CANADIAN Nurse Journal report (Kerr), 357
 C.N.A. at U.B.C., (ed.), 611
 CANADIAN Nurses' Association:
 Citizens' forum, 209
 Financial statements (1950), 354
 General interest sessions (1950), list of, 481
 Nomination ticket (1950-52), 309
 Program of 25th general meeting, 310
 Proposed amendments (1950), 364
 Registrars' conference, 207

- Resolutions regarding:
 Educational qualifications debar from advanced work, 208
 Evaluation and accreditation of schools of nursing, 208
 Financial support for schools of nursing, 907
 General interest sessions, 908
 National emergency, 684, 907
 Nurses' salaries as gross salaries, 208
 Official statement of content of course, 208
 Reciprocal registration difficulties, 207
 Report of the study committee on public health practice in Canada, 908
 Statistical report (Archibald), 351
What you want to know about nursing, 482
 CANADIAN Red Cross Society:
 Appointments, transfers, and resignations, 968
 CANCER:
 Chemotherapy of (Taylor), 875
 research in pictures (St. Maurice), 173
 Treatment facilities, 399
 CANCER research in pictures (St. Maurice), 173
 CARDIAC catheterization:
 Study of congenital heart disease by (Brown, England, Hauch, Lewis), 548
 CARE of His Majesty (Bell), 981
 CARPENTER, Helen M. & por., 804
 Staff education work conference, 824
 CASE of the poisoned cup (Ranta), 275
 CAUSES of death, 920
 CHANGE of life (Edsall), (rev.), 319
 CHANGING maternity service in a changing world (Corbin), 949
 CHARD, H. F. (West, Bowerman)
Handbook for industrial nurses (rev.), 919
 CHEMOTHERAPY of cancer (Taylor), 875
 CHERKASKY, Martin (por.), 825
 CHILD psychology:
 Building maturity (Schram), 881
 Talking back, 61
 Temper tantrums, 52
 Thumb sucking, 66
 CHITTICK, Rae & por., 300
 CHLOROMYCETIN therapy (Davies), 731
 CHRISTIAN fellowship, 135, 387
 CHRONIC arthritis (Robinson), 525
 CHRONIC illness:
 Occupational therapy for (Stocker), 532
 Meeting the total needs of long-term patients (Gage), 825
 CLAIRE, Sister Mary & por., 806
 Evaluation and accreditation work conference, 819
 CLANCY, Vera
 Industrial nurses confer, 814
 CLARE Marie, Sister
 Nutritional anemia, 575
 CLARK, Jean S., 84, & por., 93, 567
 Echoes from the foothills (ed.), 93
 CLARK, Muriel
 Closing the gap in the tuberculosis program, 721
 CLERMONT, Sister Delia & por., 806
 CLINICAL instruction (Brown), (rev.), 224
 CLOSING the gap in the tuberculosis program (Clark), 721
 COLOR, line and balance (Loyola), 34
 COLOSTOMIES:
 Travail d'équipe en nursing (Préfontaine) 396
 COLUMKILLE, Sister, 252, & por., 259
 Motivation (poem), 260
 Welcome to all (ed.), 259
 COMMITTEE on constitution, by-laws and legislation (Fidler), 364
 COMMUNICABLE disease nursing (Lynch), (rev.), 918
 COMMUNICABLE diseases:
 Acute anterior poliomyelitis (McCarthy), 793
 Battle against leprosy (Ast), 547
 Chloromycetin therapy (Davies), 731
 Common cold, 116
 New look in typhoid fever (Thirlaway), 729
 Scabies prophylaxis, 66
 Tetanus (Rutherford), 394
 Yaws control, 887
 COMMUNICABLE diseases and their nursing care (Pearce), (rev.), 663
 COMMUNITY health services:
 Family service in a generalized health agency (Willis), 122
 Integration of hospital and (Holmes), 119
 CONSTRUCTION of hospitals (Beyer), 107
 CONVENTION story (ed.), 611
 COOPERATION in health services (Mellish), 833
 CO-OPERATIVE venture (Warner), 98
 COPLE, Ernest L.
 Pellagra, 669
 CORBIN, Hazel
 Changing maternity service in a changing world, 949
 CORMIER, Thelma
 How people live, 400
 CORNWALL, Norah K.
 R.C.N. civilian health department, 31
 CORONARY occlusion, signs, 65
 CORPUS luteal hemorrhage, surgery and nursing care (Harvie), 910
 CORRECT procedure in a toast, 524
 CORWIN, E. H. L.
Ecology of health (rev.), 844
 COSH, Nora
 Esophagectomy and gastro-esophagostomy, 197
 COUNSELLING and guidance:
 Idealism and the first-year student nurse (Mooney), 807
 Whose the responsibility, 571
 COUNSELLING for nurses (Black), 818
 COUSENS, Helen M.
Nursery age (rev.), 662
 CRADLE song (poem), 977
 CREELMAN, writes, Lyle, 477, 565, 658, 739, 799, 888, 976
 CRIPPLED children:
 Camping for (Ross), 543
 CRYDERMAN, Ethel M. & por., 802
 Immediate task, 693

D

- DARRACH, Verna
 New year greetings (ed.), 13
 DAVIES, Marian M.
 Chloromycetin therapy, 731
 DEANE, Dora
 Mrs. Jones had enough, 219

DEFINITIONS of functions (Tougas), 535
 DEMARSH, Kathleen Grace & por., 190
 DEMERS, Cécile
 Semaine de santé à Lévis, 43
 DEMONSTRATION school administration committee (Fidler), 829
 DENTAL health and hygiene:
 Dentists use tests, 742
 Fluorides, 289
 DETACHMENT of the retina (McCulloch), 872
 DEVELOPING the social and health aspects of nursing (Lawson), 641
 DEVELOPMENTS in Toronto (ed.), 869
 DIABETES:
 Hidden, with psychosis (MacLeod), 643
 DIAGNOSIS and treatment of epilepsy (Gould), 177
 DIFFERENTIAL diagnosis in chest pain (Leaman), 65
 DISTRIBUTE created wealth, 571
 DOBBS, Mildred, 463
 DOWN, E.
 Plasters and splints, 19
 DREAM come true (Felicitas), 293
 DRUGS:
 Aesculin, 606; Alenteryl, 688; Aludrine hydrochloride, 430; Amabile cho, 688; Amotricin, 86; Anacobin, 606; Ancatropine, infant S.T., 86; AN-T-B tablets, 782; Antihistaminic preparations, 323; Artane tablets, 6; Aureomycin hydrochloride ointment (ophthalmic), 864; Avlon tablets, 519; Bacidrin, 88; Baciguent ointment, 8; Bacitracin, 8; Bisterone suspension, 782; Cadrosol tablets, 606; Calcydic granules and tablets, 256; Caluate ampoules, 864; Cam-cell tablets, 608; Carbocel, 342; Catagen, 944; Caubren compound tablets, 340; Cenolate ampoules, 784; Cetavlon, 519; Charkolin granules, 256; Chloromycetin, 731; Chloromycetin capsules, 862; Cholotropin tablets, 254; Chromadren, 688; Cinbisal, 942; Cobenzil, 166; Colmin tablets and nasal solution, 86; Coramine-adenosine, 166; Coramine-glucose, 166; Coricidin, 6; Corophyllin tablets and suppositories, 864; Danilone, 606; Decyl encotes, 520; Degalol, 256; Derm cream, 432; Desanca tablets, 8; Dexobese A-B-C, 686; Disprin tablets, 518; Domeboro tabs powder, 8; Dramamine tablets, 8; d-Tubocurarine chloride solution, 519; Eskell, 782; Estro-bene tablets, 688; Eulissin, 518; Exorbin, 342; Fensobar powder, tablets, liquid, 6; Ferrodic granules, 256; Gantrisin, 168; Gericole, 944; Glycurrant, 518; Graminasin, 430; Gramoderm, 256, 430; Gramollets, 430; Graval suppositories, 784; Hexathide, 862; Histadyl and surfacaine lotion and cream, 88; Inositol tablets, 606; Isoprenaline sulphate, 862; Khellvis, 942; Leptazol ampoules, 254; Lipo-adrenal cortex, 784; Macron tablets, 430; Masse nipple cream, 784; Mercodol syrup with decapryn, 518; Mercuhydrin tablets, 254; Methadon, 340; Methiol granules, 686; Metrasil tablets, 342; Nembutal sodium solution, 168; Neo-antergan expectorant, 88; Neo-antergan

suppositories, 168; Neovacgen, 944; Nethaprin capsules, 784; Nethaprin syrup, 254; Nitranitol with phenobarbital and theophylline tablets, 518; Oil of wintergreen is dangerous (Theakston), 448; Orthoxicol, 168; Paludrine, 519; Paraaminosalicylic tablets, 432; Paradione, 166; Paradione solution, 520; Pregnenolone, 340; Presto-boro powder, 340; Procaine hydrochloride 0.2% intravenous, 432; Progesterone hypoglossals, 518; Protamide ampoules, 686; Protamine sulphate ampoules, 254; Pyribenzamine nebulizer, 342; Pyridoxine hydrochloride ampoules, 782; Pyrithen compound, 168; Quadronal tablets, 8; Rhopas, 519; Rikitol emulsion, 942; Roniacol, 608; Rubramin capsules, 608; Sederal, 864; Sedulon, 254; Sigmodal sodium solution, 256; Sodec, 256; Sodium gentisate, 520; Sorparin, 88; Sudroma, 864; Sulestrex piperazine, 520; Syndrox hydrochloride, 86; Synkavite—CB, 8; Synthetic curare (Haslett), 579; Terramycin elixir, 862; Testandrone hypoglossals, 686; Thenylene hydrochloride cream, 166; Thephorin lotion, 6; Thepryl expectorant, 942; Theptine, 608; Tracinets, 944; Tri-immunol, 340; Trilene, 520; Tronic compound, 432; Viacutan solution, cream, 519; Vibelan, 688; Vioform cream, ointment, 782; Volugel, 784; Wychol, 942; Zymatinic drops, 608

DUBE, Sister Stella M.

Nurse and the rural community, 290

DUFF, L. Blake

Magic and medicine, 29

DURRANT, Helen Ruth & por., 299

E

ECHOES from the foothills (Clark), (ed.), 93

ECOLOGY of health (Corwin), (rev.), 844

EDGAR, Margery (rev.), 584

EDITORIAL board (Mathewson), 358

EDITORIALS:

C.N.A. at U.B.C., 611

Developments in Toronto, 869

Echoes from the foothills (Clark), 93

Great expectations (Miller), 171

Highest possible level, 523

New year greetings (Hall, Van Dusen,

Wright, Pettigrew, Law, Watson, Walker,

Darrach, Street, Wilson), 11

Pride tempered by humility (McArthur), 789

Spring or a pond, 437

Unto you is born, 947

Welcome to all (Columkille), 259

EDSALL, F. S.

Change of life (rev.), 319

EDUCATIONAL Policy Committee:

Evaluation of schools of nursing, 133

Government support for nursing education, 134

EDUCATIONAL policy committee (MacLeod), 370

EDWARDS, Joan

Highlights of treaty at Oxford House, 632

EDWARDS, Mary P. (rev.), 319

- EINARSON, Clara (Sigmundson)
Nursing the hypertensive, 455
ELASTOPLAST, waterproof, 686
ELLIS, Kathleen W. & por., 902
EMERSON, Blanche (rev.), 665
EMOND, Margaret, 131
EMORY, Florence H. M. 84, (por.), 713
Committee on health insurance, 377
Nursing service (1950), 103
Structure study committee, 745
World force in nursing, 713
EMPLOYMENT of the epileptic (Goodman), 180
ENGLAND, N. J. (Brown, Hauch, Lewis)
Study of congenital heart disease by cardiac catheterization, 548
EPILATION, 645
EPILEPSY:
Diagnosis and treatment of (Gould), 177
Employment of the epileptic (Goodman), 180
as a school health problem (Hawkins), 182
EPILEPSY and convulsive disorders in children (Bridge), (rev.), 581
EPILEPSY as a school health problem (Hawkins), 182
ESCOTT, Kathleen R. & por., 737
ESOPHAGECTOMY and gastro-esophagostomy (Cosh), 197
ESSENTIALS of gynecology (Brady, Kurtz, McLaughlin), (rev.), 916
ESSENTIALS of public health (Shepard), (rev.), 665
ETHERINGTON, Helen Elizabeth, 904
EVALUATION and accreditation work conference (Claire), 819
EVALUATION of schools of nursing, 112
EVALUATION of schools of nursing (Lefebvre), 278
EXCHANGE of nurses committee (Mackenzie), 382, 747
EXPERIMENT in medical education, 572
EXPERT committee on nursing, report, 741
EYE care:
Good light needed, 619
EYE conditions:
Detachment of the retina (McCulloch), 872
emergencies (Wolstein), 870
EYE, ear, nose and throat manual for nurses (Parkinson), (rev.), 226
EYE emergencies (Wolstein), 870

F

- FACT sheet on labor relations (R.N.A.B.C.), 60
FADDIS, Margene O. (Hayman)
Textbook of pharmacology for nurses (rev.), 844
FAIR, Laura B. (rev.), 842
FAMILY service in a generalized health agency (Willis), 122
FAXON, Nathaniel W.
Hospital in contemporary life (rev.), 63
FEISEL, Kay, 190
FELDMAN, Louis L. (King)
Office management for health workers (rev.), 319
FELICITAS, Sister Mary
A dream come true, 293
FENWICK, Ethel J.
Stryker frame, 117

- FIDLER, Nettie D. & por., 805
Committee on constitution, by-laws and legislation, 364
Demonstration school administration committee, 829
Interim committee on provision of nursing service, 746
Metropolitan school of nursing biennial report, 373
New residence opened, 114
FILMS:
and filmstrips, 860
FINUCANE, T. (rev.), 843
FIRST aid:
Hints on general (Hoffman), 886
FLETT, Aileen (rev.), 918
FLORENCE Nightingale International Foundation, 113
FLUORIDES, 289
FOOD parcels to nurses in Great Britain, 684
FOOT conditions:
My feet are killing me (Kelly), 287
FOREIGN countries:
Bermuda—
Ambulance duty (Ainsworth), 285
Denmark—
International group excursion in, 203
Japan—
Memorial library—Natsuye Inouye, 55
Norway—
Nursing in, 840
FOREST, Sister Jeanne (MacLennan)
Committee on archives, 382
FORMAN, Mary
Home thoughts from afar (poem), 878
FORTIER, Sister Paulette (O'Hara)
We were skeptics, 891
FRACTURES:
Injuries to bones and joints (Whyte), 15
Plasters and splints (Down), 19
FRACTURES and orthopedic surgery for nurses and masseuses (Naylor), (rev.), 226
FREEMAN, Ruth B.
Techniques of supervision in public health nursing, (rev.), 582
FRENCH work conference (Giroux), 820
FUNCTIONS of the nurse:
intravenous therapy, 135
FUNSTEN, Robert V. (Calderwood)
Orthopedic nursing (rev.), 664

G

- GAGE, Alice
Meeting the total needs of the long-term patient, 825
GAGNON, Jacqueline
Travail médico-social, 474
GASTRO-INTESTINAL conditions:
Bile, 183
Esophagectomy and gastro-esophagostomy (Cosh), 197
Travail d'équipe en nursing (Préfontaine), 396
GAUVIN, Evelyne
L'infirmière en service industriel, 297
GAW, Ruth, 563
GENERAL history of nursing (Seymer), (rev.), 581
GENERAL interest sessions (1950), list of, 481
GENERAL interest sessions (McLean-Bell), 828

GENERAL secretary, report of (Hall), 347
 GENIK, Carrie B., 904
 GERARD, Sister Catherine & por., 806
 GIBSON, F.
 Menopause, 879
 GIBSON, Margaret (rev.), 321
 GIBSON, Miriam L. (rev.), 62
 GIBSON, Shirley E. (Brown)
 Learning by seeing, 660
 GILLIES, Barbara (rev.), 844
 GILLIS, Christina
 Professional adjustments, 314
 GIROUX, Suzanne
 Assurances sociales, 204
 French work conference, 820
 Mademoiselle radio 1950, 128
 GODDARD, E. S.
 Some concepts of psychiatric nursing, 98
 GODFREY, Margaret, 190
 GOODALL, Frances, 684
 GOODMAN, H. E.
 Employment of the epileptic, 180
 GOULD, C. E.
 Diagnosis and treatment of epilepsy, 177
 GRACE, Sister Mary, 806
 GRADUATION diploma (Rogers), 402
 GRAHAM, Clara (rev.), 582
 GRAHAM, Eleanor Scott & por., 46
 GRAHAM, Joan
 Student affiliates with the V.O.N., 749
 GRAY, Constance
 Prenatal classes in Greater Toronto, 960
 GREAT Britain:
 National health service, 50
 GREAT expectations (Miller), (ed.), 171
 GREVILLE, Theresa (rev.), 919
 GRIFFIN, Dorothy Low (Beamish, Adamson)
 Hypertension, 449
 GRIFFITH, Harold R.
 Recovery room, 791
 GRIFFITH, Olive Frances & por., 299
 GROUP dynamics, 304
 GYNECOLOGICAL conditions:
 Corpus luteal hemorrhage surgery and
 nursing care (Harvie), 910

H

HADRILL, Beatrice Mary, 389
 HALL, Gertrude M.
 New year greetings (ed.), 11
 Report of general secretary, 353
 HAMLET on the maternity ward, 974
 HAMPTON, Isabel A.
 Nursing of the sick—1893, (rev.), 318
 HANDBOOK for the assistant nurse (Swire),
 (rev.), 64
 HANDBOOK for industrial nurses (West,
 Bowerman, Chard), (rev.), 919
 HARRINGTON, June
 What I think about nursing, 218
 HARVIE, Carolyn F.
 Corpus luteal hemorrhage, surgery and
 nursing care, 910
 HASLETT, A. W.
 Synthetic curare, 579
 HATCHER, William H.
 An introduction to chemical science (rev.),
 150
 HAUCH, P. P. (Brown, England, Lewis)
 Study of congenital heart disease by cardiac
 catheterization, 548

HAWKINS, Mary E.
 Epilepsy as a school health problem, 182
 HAYMAN, Joseph M. (Faddis)
 Textbook of pharmacology for nurses (rev.),
 844
 HEALTH co-ordinator:
 Developing the social and health aspects of
 nursing (Lawson), 641
 HEALTH education:
 Teacher-nurse team (Marshall), 895
 HEALTH examination and the worker, 572
 HEALTH insurance:
 Assurances sociales (Giroux), 204
 Committee on (Emory), 377
 HEALTH services, cooperation in (Mellish),
 833
 HEALTH survey in the far north (McCann),
 626
 HEALTH units:
 Problems in the establishment of (Mac-
 Lachlan), 37
 HEALTH week:
 project, 470
 Semaine de santé à Lévis (Demers), 43
 HEART disease:
 Cardiac survivals, 1001
 Differential diagnosis in chest pain (Lea-
 man), 65
 Study of congenital, by cardiac cathe-
 terization (Brown, England, Hauch,
 Lewis), 548
 HEDWIG, Sister M. (rev.), 150
 HEMOLYTIC disease (Kelley), 995
 HENDERSON, Mary E.
 Aims of professional education, 638
 HERMAN, Blanche Gertrude & por., 47
 HESS, Julius H. (Lundeen)
 The premature infant (rev.), 586
 HIBBERT, Dorothy, 905
 HIDDEN diabetes with psychosis (Macleod),
 643
 HIGHEST possible level (ed.), 523
 HIGHLIGHTS of treaty at Oxford House
 (Edwards), 632
 HINTS on general first aid (Hoffman), 886
 HISTORICAL:
 British Columbia (Ireland), 261
 In the good old days (*The Canadian Nurse*),
 14, 139, 196, 289, 385, 464, 553, 640, 720,
 801, 898, 984
 Mack training school for nurses (Rogers),
 402
 St. Mary' Hospital, Montreal (Felicitas),
 293
 HISTORY of nursing:
 Florence Nightingale (Whitton), 699
 Mary Agnes Snively (Whitton), 699
 in Osler's student days (MacDermot), 222
 HOBBIES, 780
 HOERR, N. L. (Jones, Osol)
 Blakiston's new Gould medical dictionary
 (rev.), 63
 HOFFMAN, O.
 Hints on general first aid, 886
 HOLLAND, Laura & por., 462
 Citation, 614
 HOLMES, Sophie
 Integration of hospital and community
 services, 119
 HOLMES, Willard S.
 Puerperal inversion of the uterus, 983

- HOME thoughts from afar (Forman), (poem), 878
- HONEY, Elva
Post-anesthetic recovery rooms, 465
- HORNER *manual* (rev.), 498
- HORWOOD, Lorna M.
Nursing team, 824
- HOSPITAL *administration for women* (MacManus), (rev.), 998
- HOSPITAL administration, short course in, 404
- HOSPITAL construction (Beyer), 107
- HOSPITAL *in contemporary life* (Faxon), (rev.), 63
- How people live (Cormier), 400
- How to turn ideas into pictures (Kleinschmidt), (rev.), 997
- HOWES, Helen Claire
Aniline dye poisoning of babies, 194
- HUGHES, F. N.
New products, 6, 86, 166, 254, 340, 430, 518, 606, 686, 782, 862, 942
- HULL, Edgar (Perrodin)
Medical nursing (rev.), 915
- HUMPHREY, Marjorie E. (rev.), 321
- HUNTER, Trenna G. & por., 803
Committee on public health nursing, 361
- HYPERTENSION (Beamish, Adamson, Griffin), 449
- I
- I had a dream (Baker), (poem), 570
- IDEALISM and the first-year student nurse (Mooney), 807
- ILLUSTRATED *handbook of simple nursing* (McCullough, Moffit), (rev.), 664
- IMMEDIATE task (Cryderman), 693
- IMMUNIZATION:
National, week, 698
Smallpox vaccine, 14
- IMPRESSIONS of a new graduate (Potvin), 733
- IMPRESSIONS of nursing:
What I have learned about nursing (Smith), 216
What I think about nursing (Harrington), 218
- IN memoriam:
Abey, Marion Eileen, 395; Affleck, Julia Ellen (Sharpe), 817; Anderson, Elizabeth, 893; Anderson, Margaret (Castell), 395; Armstrong, Mabel, 54; Armstrong, Mary A. (Holt), 192
Babbitt, Bessie Louise, 817; Bean, Charlotte (Foster), 463; Beck, Florence Emily, 817; Beckhorn, Ethel M. (Roblin), 131; Boyle, Lillie, 817; Buscombe, Ivy Irene, 395
Chalae, Ella May, 302; Christie, Norah T., 893; Clark, Caro, 463; Clark, Stella Belle (Taylor), 817; Clow, Lucy Ermina, 817; Connal, Jessie Alexander, 463; Coon, Elma Ruth, 659; Corbishley, Jean, 659
Ellis, Elva (Stevens), 302; Embury, Florence, 192
Fairweather, Mary Robena, 54; Firth, Grace J., 395; Fisher, Mary Elizabeth, 192; Flanagan, Louise, 563
Gerard, Ellen, 302; Gleason, Mary, 302; Gordon, Madaline (Duncan), 563; Gordon, Mary E. (McLeod), 131; Gowans, Birdie (Campbell), 192; Grant, Jessie Ellen, 817; Gray, Jane Lawrie, 1000
Haddock, Susan, 131; Hamel, Pearl (Watson), 1000; Hamilton, Frances M. (Clements), 395; Hendry, Jean (Roberts), 395; Hishon, Eleanor (O'Brien), 192
Jamieson, Jean Bernice (Myles), 659; Johnston, Mary C., 893; Jones, Catherine Vera, 659
Keary, Millicent, 817; Kelly, Annie (Craig), 893; Kennedy, Mabel (Tangney), 54; Kenny, Elizabeth J., 563
Lang, Katherine W. (Ryan), 659; Lee, Teresa (Carey), 54; Linton, Ethel (MacDonald), 54; Lloyd, Cora M., 1000
MacLaren, Ethel Blanche (Christie), 1000; MacQueen, Mary C., 192; Marcellus, Zella, 893; Mathewson, Mary Mona (Ganderton), 54; McConnell, Betty (McRobbie), 659; McDowell, Agnes (Parley), 893; McKinnon, Jessie, 131; McMillan, Claribel, 131; McQuillan, Catherine Alice, 1000; Meekins, Violet (Davies), 192; Meikle, Hilda, 817; Monroe, Winnifred E. (Forbes), 564; Montgomery, Nora B., 564; Mortimer, Jessie M., 659
Neill, Agnes C. & por., 564
O'Connor, Katherine Theresa, 192; Orr, Edna & por., 893; O'Shaughnessy, Alice Marguerite (Lecours), 817
Parchem, Lucy Marie, 54; Parker, Louise (Steel), 894; Phillips, Jacqueline, 464
Reekie, J. Ruth, 54; Reid, Dora, 54; Retallick, Maude E., 192; Richmond, Jessie Margaret (Peele), 894; Robertson, Donald, 193; Ross, Annabell, 894; Rouse, Rose Marie, 131
Sage, Christina, 54; Schonberg, Muriel (Pickup), 395; Shillinglaw, Elizabeth (Monteith), 395; Shore, Stella (Ashfield), 1000; Sime, Laura, 302; Sinclair, Jean (Aitkenhead), 302; Smiley, Lily, 302; Smith, Mary, 395; Spooner, Roe A., 464; St. James, Sister, 55; Stewart, Alice Ellen, 131; Stewart, Dorothy Margaret, 1000; Stewart, Mary Catherine, 564
Thomson, Harriet, 1000
Ure, Evelyn (Dawe), 564; Usher, Jean, 131
Van Dusen, Letitia (Jones), 894
Wall, Florence (Newell), 193; Watson, Leola, 302; Watson, Margaret Morris, 193; Whitaker, Edith (Gillies), 1000; White, Agnes, 894; Winterhalt, Veronica, 55; Wood, Dorothy (Hoover), 564
- INDIANS:
Health survey in the far north (McCann), 626
Highlights of treaty at Oxford House (Edwards), 632
Nursing on Canada's rooftop (Maison), 621
Population, 604
- INDUSTRIAL health services, 147
- INDUSTRIAL nurses confer (Clancy), 814
- INDUSTRIAL nursing:
Infirmière en service industriel (Gauvin), 297
Medical care for workers, 743
- INFANT welfare:
Care of His Majesty (Bell), 981
- INFIRMIÈRE en service industriel (Gauvin), 297

- INGHAM, Mary E. & por., 905
 INJURIES to bones and joints (Whyte), 15
 INSTITUTES:
 Head nurses (Logan) 580
 Industrial nurses confer (Clancy), 814
 Quebec industrial nurses, 383
 Short course in hospital administration, 404
 INSTITUTIONAL nursing, committee on (Paliser), 359
 INTEGRATION of hospital and community services (Holmes), 119
 INTERIOR decorating:
 Color, line and balance (Loyola), 34
 INTERNATIONAL Council of Nurses:
 World force in nursing (Emory), 713
 INTERNATIONAL *Nursing Bulletin*, 18
 INTERNATIONAL pharmacopeia, 989
 INTERNATIONAL standards for biological substances, 989
 INTERNATIONAL statistical classification of diseases, injuries and causes of death, 990
 INTRODUCTION to chemical science (Hatcher), (rev.), 150
 IRELAND, Willard E.
 British Columbia, 261

J

- JAMIESON, J. (por.), 617
 JENSEN, Deborah MacLurg (Jensen)
 Nursing in clinical medicine (rev.), 751
 JENSEN, Julius (Jensen)
 Nursing in clinical medicine (rev.), 751
 JERMYN, E.
 Problems in nursing arthritics, 530
 JOB analysis of nursing positions (Peterson), 820
 JOB analysis of nursing services, 307
 JOHNSON, Grace E. & por., 389
 JOHNSON, Ida Evelyn & por., 130
 JONES, H. W. (Hoerr, Osol)
 Blakiston's new Gould medical dictionary (rev.), 63
 JOYCE, Grace Inglis, 904
 JULEFF, Jean
 Student Nurses' Association of British Columbia, 402

K

- KEELER, Hazel Bernice & por., 978
 KELLEY, Ruth
 Hemolytic disease, 995
 KELLY, Grace
 My feet are killing me, 287
 KEMBLE, James
 Surgery for nurses (rev.), 584
 KERR, Margaret E.
 Canadian Nurse Journal report, 357
 Committee on student nurse activities report, 380
 War memorial committee report, 384
 KESSLER, Evelyn & por., 980
 KEY, Barbara
 Committee on private duty nursing, 360
 KING, Frances (Feldman)
 Office management for health workers (rev.), 319
 KING, Helen M.
 Auxiliary workers in hospitals, 558
 KLEINSCHMIDT, H. E.
 How to turn ideas into pictures (rev.), 997

- KRAKOWER, Hyman
 Tests and measurements (rev.), 62
 KURTZ, Ethna L. (Brady, McLaughlin)
 Essentials of gynecology (rev.), 916

L

- LABOR relations:
 Fact sheet on (B.C.), 60
 LABOR relations committee (Broadfoot), 374
 LAFLAIR, Mrs. J. P., 131
 LAMARRE, Geneviève
 Service social à l'école des infirmières, 899
 LAMP is heavy (Russell), (rev.), 320
 LAPLANTE, Sister, 300
 LAROSE, M. Vicki & por., 190
 LAW:
 Nurse and the (Ledoux), 478, 538, 635
 LAW, Alma F.
 Annual meeting in New Brunswick, 214
 New year greetings (ed.), 12
 LAWSON, Irene
 Developing the social and health aspects of nursing, 641
 LEADERSHIP:
 Nurse and the rural community (Dube), 290
 LEAMAN, William G.
 Differential diagnosis in chest pain, 65
 LEARNING by seeing (Brown, Gibson), 660
 LEDOUX, Carl
 Nurse and the law, 478, 538, 635
 LEFEBVRE, Sister Denise & por., 805
 Evaluation of schools of nursing, 278
 LEMKAU, Paul V.
 Mental hygiene in public health (rev.), 996
 LETTNER family & por., 127
 LEWIS, H. Berniece, 48
 LEWIS, J. A. (Brown, England, Hauch)
 Study of congenital heart disease by cardiac catheterization, 548
 LICHEN planus (O'Kane, McCawell), 41
 LINDBLAD, Anne Hahn (Struve)
 Aides dans l'équipe en nursing, 554, 649
 LINDBURGH, Marion & por., 388
 Citation, 612
 LITTLE, Walter M.
 Naval medicine, 883
 LOAN and bursary committee (Townsend), 384
 LOGAN, Elizabeth
 Head nurses' institute, 580
 LOWRIE, Isabel, 563
 LOYOLA, Sister Frances
 Color, line and balance, 34
 LUMBAR puncture headache, 68
 LUNDEEN, Evelyn C. (Hess)
 The premature infant (rev.), 586
 LUSTED, Hester
 Nurses' part in postnatal care, 966
 LYLE Creelman writes, 477, 565, 658, 739, 799, 888, 976
 LYNCH, Theresa I.
 Communicable disease nursing (rev.), 918
 LYND, Helen Jean & por., 389

M

- MCARTHUR, Helen G. & por., 620, 802
 President, 620
 Pride tempered by humility, 789
 Public relations committee, 380

- McCANN, E. K. (por.), 617
 McCANN, Mary E.
 Health survey in the far north, 626
 MCCARTHY, Annabel
 Acute anterior poliomyelitis, 793
 McCAWELL, Agnes (O'Kane)
 Lichen planus, 41
 McCULLOCH, Jean
 Detachment of the retina, 872
 McCULLOUGH, Wava (Moffit)
 Illustrated handbook of simple nursing (rev.), 664
 McDOWELL, Edith M. (MacLaren)
 Adventure in nursing, 100
 McFADDEN, Charles J.
 Medical ethics (rev.), 843
 McILRAITH, Kate
 Nurses' part in a prenatal program, 957
 MCKEAN, E.
 Paraplegic patient, 391
 MCKEOWN, Dorothy (rev.), 663
 McLAUGHLIN, Eileen (Brady, Kurtz)
 Essentials of gynecology (rev.), 916
 MCLEAN-BELL, Janet M. G.
 General interest sessions, 828
 McLEARN, Kathryn (rev.), 226
 McLEAY, Etta, 463
 MACBRYDE, Cyril Mitchell
 Signs and symptoms—their clinical interpretation (rev.), 918
 MACDERMOT, H. E.
 Nursing in Osler's student days, 222
 MACDONALD, Miriam C., 905
 MACFARLAND, Mary E. & por., 804
 MACKAY, Janet Christina & por., 979
 MACKENZIE, Margaret, 979, (por.), 980
 MACKENZIE, Norena S.
 Exchange of nurses committee, 382, 747
 MACLACHLAN, Isabel E.
 Methemoglobinemia, 140
 MACLACHLAN, Margaret
 Problems in the establishment of a health unit, 37
 MACLAREN, Mima M. (McDowell)
 Adventure in nursing, 100
 MACLENNAN, E. A. Electa (Forest)
 Committee on archives, 382
 MACLEOD, Agnes J.
 Educational policy committee, 370
 Who is responsible, 460
 Yesterday was graduation day, 271
 MACLEOD, Christine
 Hidden diabetes with psychosis, 643
 MACMANUS, Emily
 Hospital administration for women (rev.), 998
 MACMASTER, Alena J., 300
 MADEMOISELLE radio 1950 (Giroux), 128
 MAGIC and medicine (Duff), 29
 MAISON, Ivy
 Nursing on Canada's rooftop, 621
 MALLORY, H. Evelyn & por., 805
 MALONE, Noreen, 804
 MALONEY, Anna, 48
 MANITOBA:
 Appointments, transfers, resignations, 476
 Highlights of treaty at Oxford House (Edwards), 632
 Interim report, 132
 New year greetings (Pettigrew), (ed.), 12
 News notes, 72, 153, 229, 326, 410, 490
 589, 757, 847, 928, 1006
 Provincial association highlights, 386
 MARBLE, Marion E. (rev.), 751
 MARSHALL, Dorothy B.
 Teacher-nurse team, 895
 MATERIA medica for nurses (Oakes, Bennett), (rev.), 998
 MATHESON, Evelyn Florence & por., 463
 MATHEWSON, Mary S.
 Editorial Board, 358
 MAUREEN, Sister (rev.), 224
 MEDICAL care for workers, 743
 MEDICAL ethics (McFadden), (rev.), 843
 MEDICAL microbiology for nurses (Neter), (rev.), 321
 MEDICAL nursing (Hull, Perrodin), (rev.), 915
 MEETING the total needs of long-term patients, 486; (Gage), 825
 MELLISH, Dulcie
 Cooperation in health services, 833
 MENOPAUSE (Gibson), 879
 MENOPAUSE (Owen), 901
 MENTAL care pilot program, 742
 MENTAL health:
 Adventure in nursing (MacLaren, McDowell), 100
 Building maturity (Schram), 881
 Pioneering in, 50
 MENTAL hygiene in public health (Lemkau), (rev.), 996
 METHEMOGLOBINEMIA (MacLachlan), 140
 METHODS of evaluating student progress, 308; (Penhale), 821
 METROPOLITAN Life Insurance Company:
 Appointments, transfers, resignations, 752, 921
 Break with the past (Burnette), 836
 METROPOLITAN School of Nursing:
 Biennial report (Fidler), 373
 Demonstration school administration committee (Fidler), 829
 New residence opened (Fidler), 114
 Registration of graduates, 135
 Yesterday was graduation day (Macleod), 271
 MILK:
 Raw, not safe, 148
 MILLER, Lorraine
 Staff studies nutrition, 810
 MILLER, Maisie K., 164, (por.), 171
 Great expectations (ed.), 171
 MILLEY, Syretha
 Strengthening the home visit, 390
 MOFFIT, Marjorie (McCullough)
 Illustrated handbook of simple nursing (rev.), 664
 MOONEY, Sister Margaret
 Idealism and the first-year student nurse, 807
 MORGAN, Dorothy, 737
 MORRISON, Jessie G. (rev.), 63
 MORRISON, Ruth M. (rev.), 499
 MORTON, W. A., 391
 MOSBY's comprehensive review of nursing (rev.), 751
 MOTHER breast feeds her baby (Anderson), 972
 MOTIVATION (Columkille), (poem), 260
 MOULTON, Evelyn Beulah & por., 904
 MRS. Jones had enough (Deane), 219

- MULLEN, M. (rev.), 64
 MULLER, Theresa Grace
Nature and direction of psychiatric nursing
 (rev.), 842
 MUNRO, Anne Catherine, 905, (por.), 906
 MUSSON, Ellen, 980
 MY feet are killing me (Kelly), 287

N

- NASAL hemorrhage, 40
 NATIONAL health week, 30
NATURE and direction of psychiatric nursing
 (Muller), (rev.), 842
 NAVAL medicine (Little), 883
 NAYLOR, Arthur
Fractures and orthopedic surgery for nurses
and masseuses (rev.), 226
 NEED for an increased population in Canada,
 571
 NEEDS of the patient, 481
 NETER, Erwin
Medical microbiology for nurses (rev.), 321
 NEW Brunswick:
 Annual meeting (Law), 214
 Interim report, 133
 New year greetings (Law), (ed.), 12
 News notes, 72, 154, 230, 327, 412, 492, 590,
 757, 848, 1006
 Provincial association highlights, 386
 NEW look in typhoid fever (Thirlaway), 729
 NEW products (Hughes), 6, 86, 166, 254, 340,
 430, 518, 606, 686, 782, 862, 942
 NEW residence opened (Fidler), 114
 NEW year greetings (ed.), (Hall, Van Dusen,
 Wright, Pettigrew, Law, Watson, Walker,
 Darrach, Street, Wilson), 11
 NEWFOUNDLAND:
 General secretary reports on, 303
 News notes, 928
 Public health nursing in (Summers), 471
 NEWS notes, 71, 152, 227, 324, 407, 488, 587,
 670, 756, 847, 926, 1003
 NICOLLE, Alice (rev.), 996
 NORQUAY, Winifred & por., 904
 NOURISHMENT for a pregnant woman (Ran-
 doin), 963
 NOVA Scotia:
 Great expectations (Miller), (ed.), 171
 Interim report, 133
 New year greetings (Watson), (ed.), 12
 News notes, 73, 230, 928, 1007
 Provincial association highlights, 386
 NURSE and the law (Ledoux), 478, 538, 635
 NURSE and the rural community (Dube), 290
 NURSE and the social revolution (Whitton),
 21
 NURSE in industry (Percy), 822
 NURSERY age (Cousens), (rev.), 662
 NURSES' aides:
 Aides dans l'équipe en nursing (Lindblad,
 Struve), 554, 649
 Auxiliary workers in hospitals (King), 558
 NURSES and nutrition (Pett), 734
 NURSES can influence thinking (Smith), 184
 NURSES' part in postnatal care (Lusted), 966
 NURSES' part in prenatal program (McIlraith),
 957
 NURSES' prayer, 738
 NURSING—an art and a science (Tracy), (rev.),
 582

- NURSING care:
 Acute anterior poliomyelitis (McCarthy),
 793
 Banti's disease (Wilms), 56
 Chloromycetin therapy (Davies), 731
 Corpus luteal hemorrhage, surgery and
 (Harvie), 910
 Esophagectomy and gastro-esophagostomy
 (Cosh), 197
 Hemolytic disease (Kelley), 995
 Hypertension (Sigmundson, Einarson), 455
 Lichen planus (O'Kane, McCawell), 41
 Methemoglobinemia (MacLachlan), 140
 New look in typhoid fever (Thirlaway), 729
 Nurses' part in postnatal care (Lusted), 966
 Nurses' part in prenatal program
 (McIlraith), 957
 Paraplegic patient (McKean), 391
 Patient on a Bradford frame (Pickens), 115
 Stryker frame (Fenwick), 117
 Tetanus (Rutherford), 394
 Travail d'équipe en nursing (Préfontaine),
 396
 NURSING education:
 Aims of professional (Henderson), 638
 NURSING in clinical medicine (Jensen, Jensen),
 (rev.), 751
 NURSING of the sick—1893 (Hampton &
 others), (rev.), 318
 NURSING on Canada's rooftop (Maison), 621
 NURSING profiles, 46, 130, 190, 299, 388, 462,
 562, 736, 802, 902, 978
 NURSING service 1950 (Emory), 103
 NURSING sisters' association, 64, 151, 189,
 323, 404, 473, 925, 1002
 NURSING statistics—tables, 352
 NURSING students' award, 580
 NURSING team, 308
 Aides dans l'équipe en nursing (Lindblad,
 Struve), 554, 649
 Team approach, 656
 Work conference on (Horwood), 824
 NURSING the hypertensive (Sigmundson,
 Einarson), 455
 NUTRITION:
 Allergies, 531
 Debunking the "R" months, 894
 Diet therapy, 813
 Food habits among the Chinese, 810; Jews,
 812; Sikhs and Hindus, 811
 Increasing vitamin C content, 215
 Milk between meals, 52
 Nourishment for a pregnant woman (Ran-
 doin), 963
 Nurses and (Pett), 734
 Staff studies (Miller), 810
 NUTRITIONAL anemia (Sister Clare Marie),
 575
 NUTRITIONAL data (Wooster, Blanck), (rev.),
 405
-
- OAKES, Lois (Bennett)
Materia medica for nurses (rev.), 998
 OBSTETRICS:
 Aperçu sur le service social à l'assistance
 maternelle (Verret), 985
 Breast feeding (Bourne), 969
 Calcium in pregnancy, 176
 Changing maternity service in a changing
 world (Corbin), 949

- Guide for teachers of prenatal classes, 940
Hamlet on the maternity ward, 974
Mother breast feeds her baby (Anderson), 972
Nourishment for a pregnant woman (Randoin), 963
Nurses' part in postnatal care (Lusted), 966
Nurses' part in prenatal program (McIlraith), 957
Prenatal classes in Greater Toronto (Gray), 960
Puerperal inversion of the uterus (Holmes), 983
Towards easier childbirth (Barnes), 964
Unto you is born (ed.), 947
OCCUPATIONAL therapy:
for the chronically ill (Stocker), 532
OCCUPATIONAL therapy for the chronically ill (Stocker), 532
OFFICE management for health workers (King, Feldman), (rev.), 319
OFFICIAL directory, 80, 160, 240, 336, 424, 504, 600, 680, 768, 856, 936, 1016
O'HARA, Mary (Fortier)
We were skeptics, 891
O'KANE, Geraldine (McCawell)
Lichen planus, 41
ONTARIO:
Appointments, transfers, resignations, 68, 206, 432, 586, 752, 845, 922, 944
Developments in Toronto (ed.), 869
Interim report, 133
New year greetings (Walker), (ed.), 13
News notes, 74, 155, 231, 328, 412, 494, 590, 672, 759, 849, 929, 1007
Prenatal classes in Greater Toronto (Gray), 960
Provincial association highlights, 386
OPERATING room technique (Alexander), (rev.), 62
ORGANIZATION and management of hospital stores (Stone), (rev.), 405
ORIENTATION et tendances en nursing, 51, 136, 209, 305, 483, 573, 656, 743, 908, 991
ORTHOPEDIC nursing:
Injuries to bones and joints (Whyte), 15
Patient on a Bradford frame (Pickens), 115
Plasters and splints (Down), 19
Stryker frame (Fenwick), 117
ORTHOPEDIC nursing (Funsten, Calderwood), (rev.), 664
O'SHAUGHNESSY, Alice (rev.), 581
OSOL, A. (Jones, Hoerr)
Blakiston's new Gould medical dictionary (rev.), 63
OWEN, Trevor
Menopause, 901
OXYGEN tents, 65
- P**
- PAE, A. Mary, 905
PALLISER, Elinor M.
Committee on institutional nursing, 359
PARAPLEGIC patient (McKean), 391
PARÉ, Simone
Service sociale des groupes, 725
PARKINSON, Roy H.
Eye, ear, nose and throat manual for nurses (rev.), 226
PARKINSON's disease, 36
PARKINSON's disease (Buchler), (rev.), 998
PASTEURIZATION:
Raw milk not safe, 148
PATIENT on a Bradford frame (Pickens), 115
PATIENT centred conference:
Developing the social and health aspects of nursing (Lawson), 641
PEARCE, Evelyn
Communicable diseases and their nursing care (rev.), 663
PEDIATRICS:
Aniline dye poisoning of babies (Howes), 194
conference, 379
Methemoglobinemia (MacLachlan), 140
PEDIATRICS and the emotional needs of the child (Witmer), (rev.), 62
PELLAGRA (Copley), 669
PENHALE, Helen
Methods of evaluating student progress, 821
PERCY, Dorothy M.
Nurse in industry, 822
PERRODIN, Cecilia M. (Hull)
Medical nursing (rev.), 915
PERSONNEL policies:
Nurses can influence thinking (Smith), 184
PETERSON, B. H.
Job analysis of nursing positions, 820
PETT, L. B.
Nurses and nutrition, 734
PETTIGREW, Lillian E.
New year greetings (ed.), 12
PETURSSON, Suzanne
Public health nurse's role with the hypertensive, 458
PHARMACOLOGY for nurses (Faddis, Hayman), (rev.), 844
PHYSIOLOGY in diseases of the heart and lungs (Altschule), (rev.), 321
PICKENS, Mary E.
Patient on a Bradford frame, 115
PIKE, Peggy (rev.), 997
PIONEERING in mental health, 50
PLASTERS and splints (Down), 19
PLUNKETT, M. (rev.), 150
PNEUMONIA:
Terramycin in, 798
POISONS:
Oil of wintergreen is dangerous (Theakston), 448
POLIOMYELITIS:
Acute anterior (McCarthy), 793
POSITIONS vacant, 77, 156, 236, 332, 419, 500, 595, 675, 763, 851, 931, 1011
POST-anesthetic recovery rooms (Honey), 465
POST-GRADUATE courses:
Agency's part in planning a student program (Weatherhead), 294
University's part in planning a student program (Weir), 201
POSTNATAL care, nurses part in (Lusted), 966
POTTS, Helen Louise, 737
POTVIN, Terry
Impressions of a new graduate, 733
PRACTICAL suggestions:
Hypodermic needles, 149
PRE-ANESTHETIC preparation (Barnett), 96
PRÉFONTAINE, Octavie
Travail d'équipe en nursing, 396

PREHER, Sister Leo Marie (Calvey)

Sociology with social problems applied to nursing (rev.), 997

PREMATURE *infant* (Hess, Lundeen), (rev.), 586

PRENATAL classes in Greater Toronto (Gray), 960

PRENATAL program, nurses part in (McIlraith), 957

PREPAID medical plans, 742

PRESIDENTIAL address (Cryderman), 693

PRIDE tempered by humility (McArthur), 789

PRINCE Edward Island:

Interim report, 133

New year greetings (Darrach), (ed.), 13

News notes, 75

Provincial association highlights, 386

PRIVATE duty nursing, committee on (Key), 360

PROBLEMS in the establishment of a health unit (MacLachlan), 37

PROBLEMS in nursing arthritics (Jermyn), 530

PROFESSIONAL adjustments (Gillis), 314

PROFESSIONAL education, aims of (Henderson), 638

PROFESSIONAL responsibilities:

Professional adjustments (Gillis), 314

Spring or a pond (ed.), 437

Who is responsible (MacLeod), 460

PROVISION of nursing service—interim committee (Fidler), 746

PSYCHIATRIC nursing:

Adventure in nursing (MacLaren, McDowell), 100

Co-operative venture (Warner), 98

Some concepts of (Goddard), 98

PUBLIC health nurse's role with the hypertensive (Petursson), 458

PUBLIC health nursing:

Developing the social and health aspects of nursing (Lawson), 641

Family service in a generalized health agency (Willis), 122

How people live (Cormier), 400

in Newfoundland (Summers), 471

Role with the hypertensive (Petursson), 458

R.C.N. civilian health department (Cornwall), 31

Strengthening the home visit (Milley), 390

PUBLIC health nursing, committee on (Hunter), 361

PUBLIC health nursing in Newfoundland (Summers), 471

PUBLIC health in the world today (Simmons), (rév.), 499

PUBLIC relations:

Nurses can influence thinking (Smith), 184

PUBLIC relations committee (McArthur), 380

PUERPERAL inversion of the uterus (Holmes), 983

PULLEN, Bertha L. (rev.), 63, & por. 803

Q

QUEBEC:

Interim report, 133

New year greetings (Street), (ed.), 13

News notes, 75, 155, 233, 330, 416, 495, 592, 673, 761, 849, 929, 1008

Provincial association highlights, 386

QUIGLEY, Florence and por., 562

R

R.C.N. civilian health department (Cornwall), 31

RANDAL, Helen (por.), 611

RANDALL, Margaret

Ward administration (rev.), 916

RANDOIN, Lucy

Nourishment for a pregnant woman, 963

RANTA, Lawrence E.

Case of the poisoned cup, 275

REA, Joyce, 684

RECOVERY room (Griffith), 791

RECOVERY room, post-anesthetic (Honey), 465

RECRUITMENT idea, 648

REESOR, Isabelle MacLean, 903

REGISTER of refugee nurses, 990

REGISTRARS' conference, 207

REID, Gertrude, 131

ROBINSON, Harold

Chronic arthritis, 525

ROGERS, E. Bell

Graduation diploma, 402

ROSARIE, Sister M.

Value of visual aids, 646

ROSS, Gretta M.

Camping for crippled children, 543

ROSS, Margot (rev.), 320

RURAL nursing:

Nurse and the rural community (Dube), 290

RUSSELL, E. Kathleen & por., 46, 113

Portrait is unveiled, 300

RUSSELL, Sheila M.

A lamp is heavy (rev.), 320

RUTHERFORD, Betty

Tetanus, 394

RYFA, Julia Helena Barbara & por., 905

S

SASKATCHEWAN:

Annual meeting (Wilson), 830

Expansion in, 740

Health survey in the far north (McCann), 626

Interim report, 133

New year greetings (Wilson), (ed.), 13

News notes, 75, 234, 330, 418, 497, 592, 761, 850, 930, 1009

Provincial association highlights, 386

Recruitment idea, 648

SAUNDERS, Margaret, 130

SAYER, John

Aids to male genito-urinary nursing (rev.), 64

SCABIES prophylaxis, 66

SCHOLARSHIPS, 146

SCHOOL children health care, 840

SCHOOL nursing:

Teacher-nurse team (Marshall), 895

SCHOOL of nursing administration:

Definitions and functions (Tougas), 535

SCHRAM, Cecilia May

Building maturity, 881

SECOND *forty years* (Stieglitz), (rev.), 63

SEMAINE de santé à Lévis (Demers), 43

SERVICE social à l'école des infirmières (Lamarre), 899

SERVICE social à l'hôpital (Ste-Fabienne), 815

- SERVICE social des groupes (Paré), 725
 SEYMER, Lucy Ridgely
 General history of nursing (rev.), 581
 SHARPE, Gladys J. & por., 802
 SHAW, Wilfred
 Textbook for midwives (rev.), 150
 SHEPARD, William P.
 Essentials of public health (rev.), 665
 SHOCK, treatment for, 994
 SHORTAGE of nurses, 481
 SHORTENED course in nursing:
 Developments in Toronto (ed.), 869
 SICKNESS survey, 989
 SIGMUNDSON, Margret (Einarson)
 Nursing the hypertensive, 455
 SIGNS and symptoms—their clinical interpretation (MacBryde), (rev.), 918
 SIMMONS, James S.
 Public health in the world today (rev.), 499
 SISTERS entered under name as Anne of the Sacred Heart, Sister. *Sisters with first name Mary or initial M indexed under second name.*
 SMITH, Margery W.
 Nurses can influence thinking, 184
 SMITH, Orma Jacklin & por., 979
 SMITH, Shirley
 What I have learned about nursing, 216
 SNIVELY memorial lecture (Whitton), 699
 SOCIAL service:
 à l'assistance maternelle (Verret), 985
 à l'école des infirmières (Lamarre), 899
 des groupes (Paré), 725
 à l'hôpital (Ste-Fabienne), 815
 Travail médico-social (Gagnon), 474
 SOCIOLOGY with social problems applied to nursing (Preher, Calvey), (rev.), 997
 SOME concepts of psychiatric nursing (Goddard), 98
 SORENSON, Marie, (rev.), 586
 SPRING or a pond (ed.), 437
 St. JOSEPH, Sister, 300
 St. MAURICE, Laurence
 Cancer research in pictures, 173
 STAFF education, 485
 STAFF education:
 Staff studies nutrition (Miller), 810
 STAFF education work conference (Carpenter), 824
 STAFF studies nutrition (Miller), 810
 STATISTICAL report, C.N.A. (Archibald), 351
 STE-FABIENNE, Soeur
 Service social à l'hôpital, 815
 STEELE, Mildred E., 131
 STEWART, Mabel M., 191
 STIEGLITZ, Edward J.
 Second forty years (rev.), 63
 STOCKER, Marguerite E.
 Occupational therapy for the chronically ill, 532
 STONE, J. E.
 Organization and management of hospital stores (rev.), 405
 STREET, Margaret M.
 Accreditation of educational programs in nursing, 187
 New year greetings (ed.), 13
 STRENGTHENING the home visit (Milley), 390
 STRUCTURE study committee (Emory), 745
 STRUVE, Mildred (Lindblad)
 Aides dans l'équipe en nursing, 554, 649
 STRYKER frame (Fenwick), 117
 STUDENT affiliates with the V.O.N. (Graham), 749
 STUDENT affiliation:
 Agency's part in planning a student program (Weatherhead), 294
 University's part in planning a student program (Weir), 201
 with the V.O.N. (Graham), 749
 STUDENT nurse activities, committee on (Kerr), 380
 STUDENT nurse recruitment, 481
 STUDENT nurse work conference, 486, (Black), 826
 STUDENT nurses' association of British Columbia (Juleff), 402
 STUDY of congenital heart disease by cardiac catheterization (Brown, England, Hauch, Lewis), 548
 SUMMERS, Elizabeth R.
 Public health nursing in Newfoundland, 471
 SUPPLY and demand in nursing:
 Nurse and the social revolution (Whitton), 21
 SURGERY for nurses (Kemble), (rev.), 584
 SWIRE, Mary E.
 Handbook for the assistant nurse (rev.), 64
 SYNTHETIC curare (Haslett), 579

T

- TAYLOR, Madeline & por., 562
 TAYLOR, Phyllis Brewster
 Chemotherapy of cancer, 875
 TEACHER-nurse team (Marshall), 895
 TEACHING methods:
 Value of visual aids (Rosarie), 646
 TECHNIQUES of supervision in public health nursing (Freeman), (rev.), 582
 TESTS and measurements (Krakower), (rev.), 62
 TETANUS (Rutherford), 394
 TEXTBOOK for midwives (Shaw), (rev.), 150
 THEAKSTON, Irene P.
 Oil of wintergreen is dangerous, 448
 THERRIEN, Berthe, 738
 THIRLAWAY, Jean
 New look in typhoid fever, 729
 THOMAS Wall scholarship, 146
 THOMSON, A. L. (rev.), 998
 TOAST to the King, correct procedure in, 524
 TONGUE important disease indicator, 838
 TOUGAS, Sister Marie-Jeanne
 Definitions of functions, 535
 TOWARDS easier childbirth (Barnes), 964
 TOWNSEND, Catherine L., 191, por. 192, (rev.), 918
 Loan and Bursary Committee, 384
 TRACY, Margaret A.
 Nursing—an art and a science (rev.), 582
 TRAVAIL d'équipe en nursing (Préfontaine), 396
 TRAVAIL médico-social (Gagnon), 474
 TREASURER, report of (Hall), 353
 TRENDS in nursing, 49, 132, 207, 303, 481, 571, 655, 741, 907, 989
 TRUMPET in the dust (Whitton), 699
 TUBERCULOSIS:
 British Columbia chest survey clinics, 1002
 Central dispensary at Stockholm, 67
 Closing the gap in the, program (Clark), 721

Compensation assured, 393
Prevention (Campbell), 67
We were skeptics (Fortier, O'Hara), 891
WHO fights, 49

U

UNDULANT fever:
Case of the poisoned cup (Ranta), 275
UNIVERSITY schools and departments of nursing—Queen's University, 201
UNIVERSITY's part in planning a student program (Weir), 201
UNTO you is born (ed.), 947

V

VALUE of visual aids (Rosarie), 646
VAN DUSEN, Clara A.
Annual meeting in Alberta, 567
New year greetings (ed.), 11
VANCOUVER by the sea (Wyness), 439
VERRET, Fernande
Aperçu sur le service social à l'assistance maternelle, 985
VICTORIAN Order of Nurses:
Appointments, transfers, resignations, 70, 129, 196, 322, 406, 438, 668, 755, 846, 924
Student affiliates with the (Graham), 749
VISUAL aids:
Learning by seeing (Brown, Gibson), 660
Value of (Rosarie), 646
VITAL statistics, 948
VITAMINS:
Pellagra, 669

W

WALES, Evelyn, 738
WALKER, Florence H.
New year greetings (ed.), 13
WAR memorial committee:
Memorial library (in Japan), 55
Report (Kerr), 384
WARD administration (Randall), (rev.), 916
WARNER, W. P.
Co-operative venture, 98
WATERMAN, Olive, 299
WATSON, Nancy
New year greetings (ed.), 12
WE were skeptics (Fortier, O'Hara), 891
WEATHERHEAD, Katherine M. (rev.), 582
Agency's part in planning a student program, 294
WEIR, George M., 131
WEIR, Jenny M. & por., 736
University's part in planning a student program, 201
WELCOME to all (Columkille), (ed.), 259
WEST, Marion M. (Bowerman, Chard)
Handbook for industrial nurses (rev.), 919
WHAT I have learned about nursing (Smith), 216
WHAT I think about nursing (Harrington), 218
WHITTON, Charlotte & por., 699
Nurse and the social revolution, 21
Trumpet in the dust, 699
WHITTY, Rhea, 736
WHO is responsible (MacLeod), 460

WHYTE, Donald
Injuries to bones and joints, 15
WILLIAMS, Beatrice E., 906
WILLIAMS, Verna (rev.), 916
WILLIS, Marjorie
Family service in a generalized health agency, 122
WILMS, Evelyn
Banti's disease, 56
WILSON, Amy, 473
WILSON, Elsie J. (rev.), 581
WILSON, Lola & por., 736
Annual meeting in Saskatchewan, 830
New year greetings (ed.), 13
WINTERGREEN, oil of, is dangerous (Theakston), 448
WISHART, J. M.
Anesthesia, 95
WITMER, Helen L.
Pediatrics and the emotional needs of the child (rev.), 62
WOLSTEIN, E.
Eye emergencies, 870
WOOSTER, Harold A. (Blank)
Nutritional data (rev.), 405
WORK conferences:
Counselling for nurses (Black), 818
Evaluation and accreditation, 53, 138; (Claire), 819
French (Giroux), 820
General plan for, 138
Job analysis of nursing positions (Peterson), 820
Job analysis of nursing services, 307
Mademoiselle radio 1950 (Giroux), 128
Meeting the total needs of long-term patients, 53, 486; (Gage), 825
Methods, 138
Methods of evaluating student progress, 308; (Penhale), 821
Nurse in industry, 212; (Percy), 822
Nursing team, 308; (Horwood), 824
Pattern, 138
Purposes, 138
Staff education, 485; (Carpenter), 824
Student nurse, 486; (Black), 826
WORKING conditions of nurses, 482
WORLD Federation for Mental Health, 50
WORLD force in nursing (Emory), 713
WORLD Health Organization:
Action of insecticides, 139
Expert committee on nursing, 480
Highest possible level (ed.), 523
Lyle Creelman writes, 477, 565, 658, 739, 799, 888, 976
Recruiting nurses, 121
WRAPPING your Christmas parcels, 988
WRIGHT, Alice L. (por.), 611
New year greetings (ed.), 12
WYNESS, Alison (por.), 617
Arrangements committee, 378
Vancouver by the sea, 439

Y

YAWS control, 887
YESTERDAY was graduation day (MacLeod), 271
YOUNG, Myra E. & por., 130

● VOLUME 46
NUMBER 1
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JANUARY
1950



THE CANADIAN NURSE

● C.N.A. BIENNIAL
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● THE NURSE AND THE
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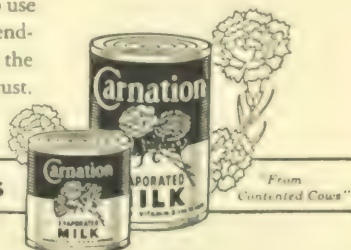
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NUMBER 1

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NEW PRODUCTS.....	6
NEW YEAR GREETINGS.....	11
INJURIES TO BONES AND JOINTS..... <i>D. Whyte, M.D.</i>	15
PLASTERS AND SPLINTS..... <i>E. Down</i>	19
THE NURSE AND THE SOCIAL REVOLUTION..... <i>C. Whitton</i>	21
MAGIC AND MEDICINE..... <i>L. B. Duff</i>	29
R.C.N. CIVILIAN HEALTH DEPARTMENT..... <i>N. K. Cornwall</i>	31
COLOR, LINE, AND BALANCE..... <i>Sr. F. Loyola</i>	34
PROBLEMS IN THE ESTABLISHMENT OF A HEALTH UNIT..... <i>M. MacLachlan</i>	37
lichen PLANUS..... <i>G. O'Kane and A. McCowell</i>	41
SEMAINE DE SANTÉ À LÉVIS..... <i>C. Demers</i>	43
NURSING PROFILES.....	46
TRENDS IN NURSING.....	49
ORIENTATION ET TENDANCES EN NURSING.....	51
WORK CONFERENCES.....	53
BANTI'S DISEASE..... <i>E. Wilms</i>	56
BOOK REVIEWS.....	62
NEWS NOTES.....	71
OFFICIAL DIRECTORY.....	80

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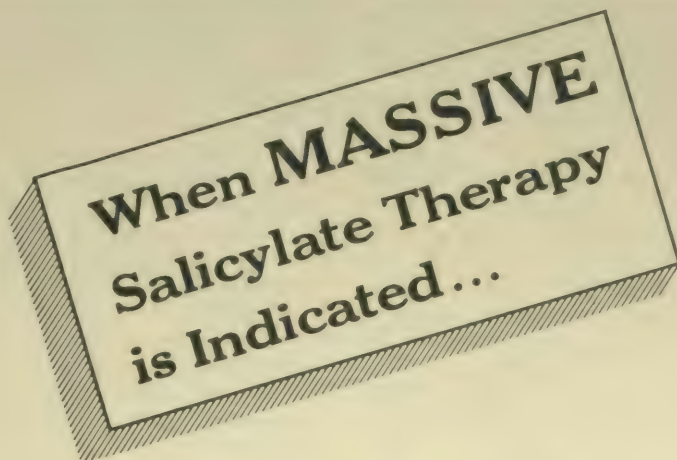
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*Probably the most indefatigable workers for nursing in Canada are the **Executive Secretaries of the nine provincial associations and our General Secretary.** They don't know that such a thing as an eight-hour day came into vogue for the nursing profession years ago! After a full day at their respective offices—handling mountains of correspondence; interviewing nurses, young and old; guiding, counselling, planning—they tear off to evening meetings or lug home a briefcase crammed with reports to be digested or new material to be sorted out and written up. A gallant, interested, hard-working, loyal group! We feel that it is particularly fitting, therefore, that our New Year's editorial page should be theirs. They bring cordial greetings and inspiration to us all.*

* * *

*When one of Canada's most outstanding women, **Dr. Charlotte Whitton,** is advertised as the guest speaker on any occasion, her eager listeners know that they will receive food for thought that will have a very tonic effect. Dr. Whitton participated in a special refresher course at the University of Toronto School of Nursing last October. The nurses who listened to her masterly summation of present-day trends received a very real challenge to dig in and find plausible answers to our problems. "If the profession fails to meet and master it, solution will come from others, for neither the mood nor patience of the present times brooks much loitering." Dr. Whitton is not a nurse nor a medical woman but her insight into the difficulties of today give her words an authoritative ring that we of the nursing profession must not evade. We are very grateful for the permission to publish this address in full so that all of our readers may square off and face the challenge with an intelligent understanding of the implications.*

* * *

*A *propos* of nurses being well-informed on their professional affairs, we were interested to read one of the remarks made by Dr. L. J. Piccoli, professor of pharmacology, Fordham University, at a dinner meeting of pharmacists in Montreal. Dr. Piccoli states: "To keep abreast of the latest developments in pharmacy, it is necessary for the pharma-*

cist to follow the professional literature and to have available—properly classified—information that he thinks may be of possible future value."

*We feel very strongly that the same thing applies to nurses. Yet with some 30,000 graduate nurses in active practice in Canada, less than 9,000 are personal subscribers to their professional *Journal*. How are the others keeping "abreast of the latest developments"? Or are they?*

* * *

*One of our recent authors, in acknowledging the complimentary copies of *The Canadian Nurse* sent to him, said: "Would it be considered an impertinence if I raised my eyebrows at the inclusion in a professional journal of the reading time of the articles? I always thought this was for people who moved their lips when they read the comics!"*

*Perhaps he is right. We have received some favorable comments on this practice, however. It certainly is an answer to the folk who tell us they "haven't time to read *The Canadian Nurse*." For example, the total time for all the articles so marked in the December issue came to 1 hour, 43 minutes, and 42 seconds!*

* * *

*The publication of the questions and answers contained in the **Fact Sheet on Labor Relations,** which was developed by the Registered Nurses' Association of British Columbia, follows the suggestion of their Labor Relations Committee. It is not intended as a lure to attract nurses to that province. Rather, it is a recognition of the fact that the R.N.A.B.C. has come to grips with some of the problems confronting members of the profession in a realistic, mid-twentieth-century fashion. Copies of the printed leaflet were mailed to each member of the association for their information and guidance. The Labor Relations Committee is proud of the accord it has established and rightly so.*

* * *

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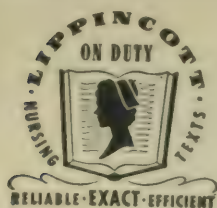
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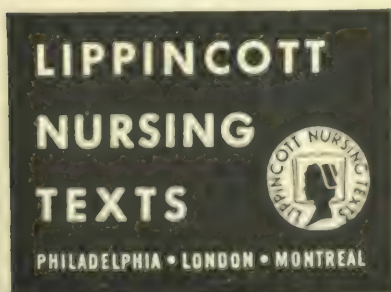
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Description—Each tablet contains

Ephedrine hydrochloride	3/8 gr.
Phenobarbitone	3/8 gr.
Phyllicin (theophylline-calcium salicylate)	2 gr.
Potassium iodide	5 gr.

Indications—Prevention of asthma and relief of moderately severe attacks. Contra-indicated in tuberculosis, hyperthyroidism, hypertension, heart disease, and diabetes. Frequent or continued use may cause nervousness, restlessness, sleeplessness.

DOMEBORO TABS POWDER

Manufacturer—Dome Chemical, Inc.; Canadian distributor: Saville Rolls Limited, Toronto.

Description—Each powder packet contains a total of 2.2 grams of aluminum sulphate and calcium acetate, to produce, when dissolved in one quart of warm tap water, a lead-free, stable, 1:40 Burow's solution, pH 4.2.

Indications—Acid douche for feminine hygiene; adjuvant therapy in vaginitis and trichomonas vaginalis.

BACIGUENT, Ointment

Manufacturer—The Upjohn Company, Toronto.

Description—Each gm. contains 500 units of antibacterial agent, Bacitracin, in a non-irritating, neutral ointment base.

Indications—The treatment of superficial infections of the skin caused by organisms susceptible to Bacitracin.

Administration—Apply locally, with or without a bandage, one or more times a day as required. For deep infections, Bacitracin-Topical should be given by local injections. If sensitization occurs, discontinue use.

BACITRACIN—Topical

Manufacturer—The Upjohn Company, Toronto.

Description—Sterile powder for preparation of wet dressings, irrigations, and local instillation. Each 25 cc. vial contains 2,000 units or 10,000 units of Bacitracin.

Indications—Infections of the skin due to organisms susceptible to Bacitracin.

SYNKAVITE—CB

Manufacturer—Hoffmann-La Roche Limited, Montreal.

Description—A gelatin capsule providing the anti-hemorrhagic effects of vitamin K, the wound-healing and detoxifying actions of vitamin C, and the therapeutic effects of four water-soluble B-complex factors.

Indications—For pre-operative and post-operative administration in tonsillar, nasal, and plastic surgery, as well as in biliary and gastrointestinal surgery.



Viscopaste BANDAGES

TRADE MARK

Viscopaste Bandages are recommended as an alternative to elastic adhesive bandaging, in the treatment of chronic varicose and eczematous conditions where a patient's skin is hyper-sensitive. The bandages have non-fray edges and are thoroughly and evenly impregnated with zinc oxide gelatin paste of the Unna type.

Viscopaste bandages are ready for immediate application as soon as the moisture-proof wrappings are removed. They set quickly, forming a thin shell and are especially valuable in the control of oedema following removal of P.O.P. casts.

Ichthopaste BANDAGES

TRADE MARK

Ichthopaste Bandages are similar to Viscopaste with the addition of 2 per cent Ichthyol and give a more resilient support. Varicose ulcers frequently respond successfully to treatment with Ichthopaste Bandages.

Both bandages carry a high paste content, four times the weight of the fabric base.

Available in 6 yd. and 10 yd. lengths by 3½ ins. wide.

Smith & Nephew Ltd.

378 St. Paul St. West

Montreal

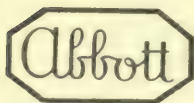


especially for them

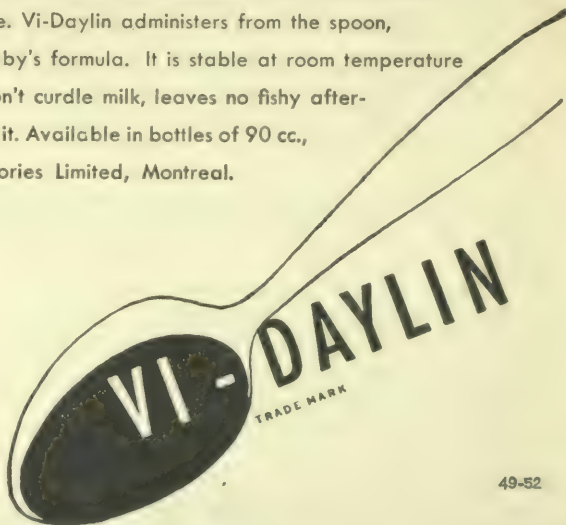
... its citrus-like flavor and odor

hide six essential vitamins

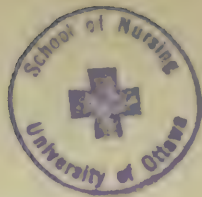
Each tasty, 5-cc. teaspoonful of Vi-Daylin contains the minimum daily requirement of vitamin A for a child 1 to 12, twice the minimum daily requirements of vitamins C, D and thiamine, and supplemental amounts of riboflavin and nicotinamide. Vi-Daylin administers from the spoon, mixes readily with cereal, juices or baby's formula. It is stable at room temperature for two years, won't stain clothing, won't curdle milk, leaves no fishy after-odor. Children and finicky oldsters love it. Available in bottles of 90 cc., and 8 fluid ounces. Abbott Laboratories Limited, Montreal.



(Homogenized Mixture of
Vitamins A, D, B₁, B₂, C and
Nicotinamide, Abbott)



49-52



The CANADIAN NURSE

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VOLUME FORTY-SIX

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New Year Greetings

"The past is inspiring, the future is challenging, the present is our responsibility." In these words, Miss Daisy Bridges conveyed to the delegates and members present at the recent Interim Conference of the International Council of Nurses in Sweden a message of vital significance to the nurses of the world.

The present is *our* responsibility . . . What food for thought this gives, especially as we enter upon a new year. Already there are signs that the apathy which has characterized the weary post-war world is being replaced by a renewed vitality and spiritual rebirth in almost all lines of human endeavor. Interesting new developments are beginning to manifest themselves in nursing. Your professional *Journal* in the coming months will bring you news of these developments. It will be important for the nurses of Canada not only to familiarize themselves with current trends, but also to participate individually and collectively in translating these from dreams to realities. A few valiant nursing leaders shaped the inspiring past. We cannot continue any longer to expect a few devoted souls to carry the whole burden of responsibility for shaping the present and the future of our profession.

It is confidently expected that the nurses of Canada will not be found wanting when they are called upon to share in the manifold tasks which lie ahead.

Gertrude M. Hall.

General Secretary, Canadian Nurses' Association

On behalf of the Alberta Association of Registered Nurses I wish to extend to all nurses in Canada our most sincere wishes for 1950. 1949 found us at the crossroads in nursing. Will 1950 pave the way to a brighter tomorrow? Only with the full co-operation and whole-hearted support of not the few

but the whole of our nursing group can we progress in the right direction. The past is but a reflection of our future achievements.

Clara A. Van Dusen

Registrar, Alberta Association of Registered Nurses

British Columbia nurses extend New Year greetings to all nurses east of the Rockies. We are busy and excited in our preparations for the role of hostess province for the biennial next June. We shall have the totem poles polished and the mountains all spruced up for our guests.

Olivia L. Wight

*Executive Secretary
Registered Nurses' Association of British Columbia*

As my New Year message, I would like to quote from "The Mature Mind" by H. A. Overstreet:

It will mean much to our confused and hostility ridden world if and when the conviction begins to dawn that the people we call "bad" are people we should call immature. This conviction would bring us to the realization of what needs to be done if our world is to be rescued from its many defects. The chief job of our culture is, then, to help all people to grow up . . . While his torturers were making his last hours more terrible than they needed to have been by adding cruelty to cruelty, Christ prayed: "Father forgive them, for they know not what they do." He saw them not as "bad" but rather as too ungrown-up even to know that their cruelty was cruelty. It is this insight—that the evil men do is the evil of their immaturity—that may yet save the world.

May this conviction and this insight guide Canadian nurses individually and collectively in 1950 and henceforth.

Lillian L. Pelligrini

*Executive Secretary and Registrar
Manitoba Association of Registered Nurses*

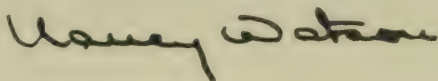
We welcome the privilege of extending a greeting to the nurses of Canada through *The Canadian Nurse*. I am pleased to join with the other provincial executive secretaries in wishing you all much happiness and success in your many endeavors through 1950.

Helma F. Law

*Executive Secretary
New Brunswick Association of Registered Nurses*

I wish on behalf of the Registered Nurses' Association of Nova Scotia to extend to all nurses throughout Canada our warmest greetings and best wishes. It is our sincere hope that the coming year may witness continued progress

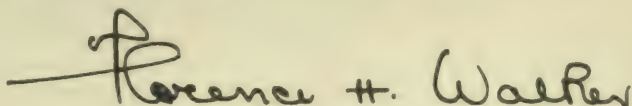
in our profession, and bring to all of us a deeper appreciation of our opportunities for service.



*Secretary-Registrar
Registered Nurses' Association of Nova Scotia*

This year is the halfway mark of the twentieth century and the twenty-fifth anniversary year of the Registered Nurses' Association of Ontario. For Ontario nurses in particular it should be a year of stock-taking, when past achievements are evaluated; and of constructive planning, when future goals are set.

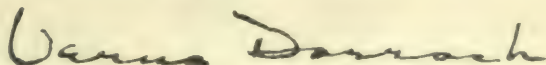
We greet Canadian nurses from British Columbia to Newfoundland and offer sincere good wishes to our sister provincial associations for a year of progress in meeting the very real problems which confront us all.



*Secretary-Treasurer
Registered Nurses' Association of Ontario*

A New Year is opening and it is a time to extend greetings. The Association of Nurses of Prince Edward Island looks forward to the New Year with courage and confidence. If we can feel this confidence when things about us are full of difficulties, it is because you, the members, are with us, ready to support and advance provincial and national projects.

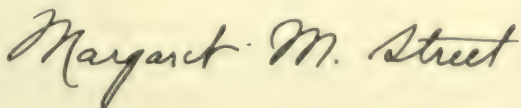
To each of you, and to all nurses we extend that old wish—a Happy New Year.



*Secretary
The Association of Nurses of Prince Edward Island*

One of the foremost leaders of Canadian nursing recently made a strong appeal that the nurses of Canada should go forward with a strong faith that obstacles would be overcome and goals achieved. This clarion-call will echo and re-echo in our minds and spirits as we enter the new year.

Faith and courage of the highest order will indeed be required if we are to accept the challenge of the future and play our full part in modern nursing developments. However, as "faith without works is dead," our faith must be accompanied by strong and concerted efforts in the interests of better care of patients through better preparation of nursing and of auxiliary nursing personnel.



*Secretary-Registrar
The Association of Nurses of the Province of Quebec*

In these days, renewed courage is needed to face the future. "Go out

into the darkness and put your hand into the Hand of God . . . " thus comes strength and courage.

All of us have rosy dreams and build fairy castles. Noble dreams and aspirations are not to be despised though in reality they must be disciplined to possibilities. We must walk straight into the tasks we can do while we keep our feet firmly on the ground. The accomplishment of each task should make a goal in our individual plan for creative achievement.

Lola Wilson

*Assistant Registrar
Saskatchewan Registered Nurses' Association*

In the Good Old Days

(The Canadian Nurse, January 1910)

"On the first day of December, 1884, Miss Mary Agnes Snively, a Canadian who had graduated from the Training School for Nurses at Bellevue Hospital, (New York), entered on her duties as Superintendent of the Training School for Nurses at Toronto General Hospital, a position of honor, trust and arduous labor which she has held ever since, to the advantage of the hospital, the profession and the community.

"On the first day of December, 1909, the twenty-fifth anniversary of her appointment, a great company of the Board of Governors, the Staff of the hospital, household, the citizens of Toronto and, above all, the nurses, a large representation of the five hundred and more trained under her, assembled in the Nurses' Residence to offer congratulations and do her honor.

"The most dramatic moment of a memorable evening arrived, when Mr. Flavelle made the impressive and unexpected announcement of Miss Snively's retirement . . . the Board of Governors had decided to present Miss Snively with a retiring allowance of \$700 during her lifetime."

* * *

"The most interesting feature of my

post-graduate course has been the high caloric diet in typhoid fever. I could not believe it possible that the trays of toast, eggs, milk, cream and junket were actually being taken in to typhoid patients who were running high temperatures. Visions of hemorrhages, perforations and kindred ills kept flitting through my head but I soon found that the patients looked bright and happy and were actually gaining weight . . . Some took as many as 6,500 calories a day.

* * *

"A nurse comes in contact continually with ill health, pain, suffering, worry, anxiety, sorrow and death. In order to preserve her own mental and physical health and poise she should have recreation. She should make a special point of taking up some interest apart from her work as a nurse . . . To be familiar with current literature and to read aloud agreeably, to be willing to join in a hand of whist, to take part in a dance, to be able to wield, even with poor effect, a racket or mallet, are small matters with an actual place in life. The nurse should be encouraged, in order to preserve a happy balance, to be at times extremely frivolous, even wildly gay."

How cold should smallpox vaccine be kept? The colder the better; well below freezing if possible. Icebox refrigeration is not cold enough for this purpose. Smallpox vaccine cannot be injured by freezing, as can serums and other vaccines. Even a single

day out of cold storage may produce detectable deterioration in potency.

In an electric refrigerator the smallpox vaccine should be kept in an ice-making compartment.

—U.S. Public Health Reports

Injuries to Bones and Joints

DONALD WHYTE, M.D., F.R.C.S. (EDIN.)

Average reading time — 12 min. 48 sec.

THE PURPOSE of this article is mainly to review the subject of fractures and to outline the objects of treatment and the methods now in use to secure these objects. However, it may not be amiss to first scan briefly the injuries that may occur to muscles, ligaments, and joints by trauma similar to that which causes fractures.

STRAINS

A strain is an injury to muscles or ligaments due to overuse. This overuse may be within the normal range but too long continued or it may be a single effort of too great a violence. An instance of the first type is the sore muscles and/or ligaments which follow taking exercise to which one is not accustomed. An example of the second is the sore back one may have after one single big effort to lift something too heavy for one's strength. Many so-called minor sprains of the ankle would be better termed "strains." Strains recover best with heat, massage, and active movements within the normal range.

SPRAINS

A sprain is a partial or complete rupture of one or more ligaments of a joint without dislocation of the joint. As some tissue has been actually torn or separated, that tissue needs complete rest and protection for a period long enough to allow it to reunite. Most sprains are best treated by immobilization in plaster of paris but, for some of the less severe ones, protection by adequate adhesive strapping may be sufficient. The final results of severe sprains of the ankle are generally much better if the patient's foot and leg is put in a plaster cast with a walking device attached or incorporated in it.

Dr. Whyte practises in Peterborough, Ont.

SUBLUXATIONS

A subluxation or a sub-dislocation is a momentary partial or complete dislocation which reduces itself immediately, leaving a very severe degree of ligament damage. The diagnosis is an assumed one when one can show clinically or under x-ray that the partial or complete dislocation can be easily repeated, without using force. This can only be done with the patient under general anesthetic or the affected joint rendered completely painless by local anesthesia. This test is very worthwhile for it enables one to assess the severity of the ligamentous and soft tissue damage and so estimate more correctly the length of time the joint must be immobilized.

Subluxations of the ankle are fairly common but the diagnosis is often missed because this test is not applied. These injuries, in the case of the ankle, need 7 or 8 weeks of complete immobilization in a walking plaster of paris cast.

DISLOCATION

A dislocation is the displacement of a bone at a joint so that it no longer occupies its normal position in relation to the other bone (or bones) of this joint. Of necessity, there must be a great deal of associated damage to ligaments and other soft tissues in the region of the dislocated joint. The treatment is to reduce the dislocation and then protect the damaged ligaments by immobilization in plaster of paris for 8 to 12 weeks.

FRACTURES

A fracture is a break in the continuity of a bone. Fractures are classified in two ways:

A—as regards the *damage done to the bone itself*:

1. *Greenstick* — a break part way through the bone of a child with the rest of the bone at that level bending instead of breaking.

2. *Simple*—the break may be transverse or oblique or spiral but it is a single line of fracture giving two fragments only.

3. *Comminuted*—there are several lines of fracture resulting in three or more fragments.

4. *Impacted*—after the bone has fractured some force has caused the broken ends to become jammed together giving a certain amount of stability at the fracture site.

B—as regards the *damage done to surrounding soft tissues* in the region of the fracture:

1. *Simple*—when there is minimal soft tissue damage.

2. *Compound*—when the skin over or near the fracture has been broken, either from within or from without, enabling the fracture to be exposed to the outside world and, therefore, in danger of becoming infected.

3. *Complicated*—when important structures, such as large blood vessels or nerves, near the fracture have been damaged.

DIAGNOSTIC CLUES

With the availability of x-ray machines and the great tendency to x-ray all injuries, clinical diagnosis of fractures has almost ceased to be an art. Nevertheless, we shall consider briefly the more important points leading to a clinical diagnosis of fracture:

1. *Pain*: Usually severe at rest and intense if the part is moved.

2. *Tenderness*: Well localized over the site of fracture.

3. *Deformity*: Not always present but when it is present, it is excellent evidence.

4. *Unnatural mobility*: If a limb moves, or can be moved, at a place where no joint normally exists then it must be fractured.

5. *Crepitation*: A sign not to be deliberately sought but if noted on accidental moving of the part it is conclusive evidence.

Small bones, like those in the wrist and ankle, may sustain a crack fracture which does not show on an early x-ray but, if re-x-rayed 10 days later, enough absorption will have occurred around the crack so that it will show.

TREATMENT OF FRACTURES

The object of the treatment is to return the bone as nearly as possible to its original shape and length and to hold it in this position as long as necessary to get union. However, the greater objective, and one often forgotten, is to restore the injured part to health with the least possible disability. In order to obtain this latter goal one may have to:

1. Be satisfied with a relatively poor reduction rather than do irreparable damage to soft tissues in an heroic attempt to get a beautiful x-ray reduction.

2. Reduce (even sometimes to zero) the period of immobilization in order to avoid, as in the aged, permanently "frozen" joints on one or both sides of the fracture. If this occurs an excellent reduction and solid union are meaningless to the patient.

Reduction: To reduce a fracture we must overcome first, the shortening, and second, the deformity which is due to angulation and/or rotation.

Immobilization: During the period of immobilization we must try to maintain first, the proper length and second, the proper alignment of the fragments.

In the majority of fractures the reduction can only be done with the aid of an anesthetic—general, spinal, or local—in order to render the manoeuvre painless to the patient and to relax his muscles so that shortening may be overcome.

METHODS OF OBTAINING REDUCTION

1. *Manual*: By merely taking hold of the limb with one hand above and one below the fracture and manipulating the parts into their normal positions.

2. *Traction*: In doing a reduction manually one uses traction also, but, under this heading, I refer to traction of a greater degree applied by some mechanical means. This traction may be applied for a few minutes only, while some method of immobilization is being applied, or it may be continued in some degree for the duration of the treatment and it then becomes part of the process of immobilization.

Screws, turnbuckles, or weights are

used to mechanically increase the strength of this traction. The traction power may be transferred to the limb by means of adhesive fastened to the skin or by a metallic device into or through the bone. This latter is referred to as *Skeletal Traction*.

There are many types of apparatus used for applying skeletal traction. Some of these are:

1. Ice-tong calipers.
2. Steinmann pins.
3. Kirschner wires.
4. Roger Anderson apparatus.
5. Stader splint.

Steinmann pins are a lot larger than Kirschner wires but they have the advantage of being stationary in the bone as they do not rotate or slide backwards and forwards. This probably reduces the incidence of infection around the pin or wire.

The last two are similar in principle as each is a mechanical reduction-immobilization machine. By means of two metal pins in each fragment the machine obtains length and alignment and then maintains this reduction until union occurs.

METHODS OF IMMOBILIZATION

1. *Splints*: Wood, metal, adhesive. These are useful in a few types of fractures. Adhesive strapping is the only practical means of splinting fractured ribs.

2. *Plaster of paris*: This is the finest of all splints because each plaster splint is tailor-made to fit the particular limb being treated. Some further comments about the use of plaster will be made later.

3. *Continuous traction*: Skin or skeletal. The same traction which is used to obtain reduction is often used continuously during treatment as a means of, or an aid in, maintaining reduction. The pull maintains the length which might otherwise be lost and the muscles surrounding the fractured bone, being kept taut by this traction, act as splints. This method of immobilization has many methods of application. Its one danger is that the bone ends may become separated at the fracture site and so delay union.

The Roger Anderson and Stader machines may be included in this group, but their side bars act as splints as well as maintaining continuous traction.

4. *Internal fixation*: This means that the fracture site is exposed by an open operation and, when reduction has been obtained, the fragments are held in position by some mechanical means applied directly to the bone. The "mechanical means" is usually metallic in nature but could be a bone graft. While a bone graft may help to maintain reduction, its main purpose is usually to improve bony union in a case of delayed or non-union. The metallic objects may be screws alone, or metal plates, or Kuntscher pins or Kirschner wires driven down the medullary cavity, or Smith-Petersen nails as in fractures of the hip. Each of these methods has its place and in that place is extremely useful, but one must always take into consideration the fact that, in the case of a closed fracture, one has to convert it into a compound fracture in order to use these methods. One, therefore, exposes the patient to the slight but real risk of osteomyelitis.

In all cases treated by continuous traction or by internal fixation of the fracture there is one potential complication of great importance. This is called *distraction*. Any separation between the fractured ends of a bone greatly delays healing and in some bones, where the blood supply is poor, a slight amount of separation or distraction may lead to non-union. This is especially true at the junction of the middle and lower thirds of the tibia. This separation may not be present when the reduction and fixation is completed but may occur later due to absorption of bone along each side of the fracture line. The rigid immobilization then prevents the fragments from being approximated by muscle pull and an area of separation persists.

PLASTER OF PARIS

Plaster may be applied padded, unpadded, or partially padded. If no swelling follows the application

of the plaster the unpadded cast no doubt gives the best immobilization. Small amounts of rubber or felt over those bony prominences which lie close under the skin probably add to the patient's comfort without appreciably detracting from the immobilization.

Early swelling following the application of plaster of paris is the main complication and is one for which the nurse should always be on the lookout. If it proceeds to the point of interfering with the blood supply to the limb, amputation may become unavoidable. The nurse can help to avoid this most unfortunate complication by frequently looking at and feeling the toes and fingers which stick out beyond the end of the cast. The danger signs are coldness, blueness, numbness, and inability to move the digits.

The surgeon can do two things to avoid this complication:

1. Split all casts as soon as applied if he thinks swelling of a severe degree is likely to occur.
2. Elevate, for the first few days, all limbs in plaster of paris.

WALKING DEVICES

Many fractures at or near the ankle or in the foot do better if the patient uses the limb while encased in plaster of paris. To make this possible many devices are added to the cast:

1. Plaster heels are built on to the cast or pieces of a rubber tire incorporated into it to act as a heel or rocker.
2. The walking iron is the most commonly-used device but it is by no means the best. It is rare to see a patient wearing

a walking iron who walks normally with it. The great tendency is to rotate the whole leg on the iron as a pivot rather than to flex the knee and walk straight ahead. Weeks after the removal of the plaster some of these people still walk with a rotating movement of the leg.

3. The wooden rocker, incorporated into the sole of the plaster, is a very satisfactory walking apparatus. It is easy and cheap to make and the patient walks with a normal movement.

4. A special boot is one of the neatest and most practical walking arrangements. It is a heavy leather boot (I use army boots) two sizes larger than the patient's correct shoe size, which is split down the front of the toe to enable it to open widely. To the sole is added a fairly thick leather metatarsal bar which is placed farther back than the usual metatarsal bar. This bar acts as a rocker. Wearing this boot, and a similar but smaller one on the well foot, a workman is able to carry on with his usual work with the fact that he is wearing a cast practically unnoticed. In some factories men are allowed to return to work wearing one of these boots when they are not allowed to work wearing a rocker or walking iron. This boot has its limitations, as the idea of wearing a big black boot, and similar footwear on the other foot, cannot be "sold" to female patients.

This is only a quick and concentrated review of injuries to bones and joints and it is, therefore, full of generalities, none of which can be taken at full face value for all injuries. It may serve, however, as a review for those whose daily work does not bring them into close contact with this branch of surgery.

A Matter of Pride

Canadian nurses take pride in their interest in international nursing affairs. More than a hundred attended the recent I.C.N. Conference in Stockholm. And yet, Miss Daisy Bridges, executive secretary of the I.C.N., wrote us recently regarding the distribution of *The International Nursing Bulletin* in Canada. She said, "We only have at present 67 subscribers in Canada. We have just deleted the names of 59 Canadian subscribers who have not paid their subscriptions, in spite of re-

mindings, since 1947." Two years overdue!

Sixty-seven subscribers in Canada! We were shocked. We wonder how the remaining 59 feel about receiving the *Bulletin* for two years free? When we consider that the subscription rate is only **One Dollar per Year**, maybe we should all feel pretty small about that insignificant 67.

Send your subscriptions in right away to: *The International Nursing Bulletin*, 19 Queen's Gate, London S.W.7, England.

Plasters and Splints

E. DOWN

Average reading time — 9 min. 36 sec.

EVER SINCE mankind has lived on the earth, there have been broken bones which somehow had to be immobilized. Splints were the first form of protection. The Egyptians in 1600 B.C. advanced beyond the primitive wooden splints and wrapped the limb in bandages of cloth, stiffened with gums or waxes. A thousand years later, Hippocrates recorded the use of bandages smeared with wax and resin. In ancient days in India, the natives used clay to make a mould for fractured limbs.

An Arabian physician, Rhazes, in the 10th Century A.D., used bandages spread with lime and egg white. Not only was the support firmer, but it had a better appearance. Egg white was used for stiffening as late as 1834. Other materials were mixed with the egg white from time to time, such as oil, vinegar, straw, etc. The chief defect of these splints was that they were not readily removable. The limb usually became very wasted and any abrasions progressed to ulcers or infections.

A British consul in Bocra reported in 1798 that plaster of paris (gypsum) was being used to encase fractured limbs. He noted the obvious advantage of this substance—that it could take the form of the limb and was thus less clumsy. Its hardness was also observed. In 1816, ground up blotting paper was added to the plaster in France. Twelve years later, physicians in Berlin devised a method of putting the limb into a wooden box and pouring liquid plaster of paris over it until the limb was almost covered. The box was removed after the plaster was set. This crude "window" allowed the fracture area to be observed and did not interfere with the immobility of the part.

Miss Down prepared this material while engaged in post-graduate study in operating-room technique.

The trend next was toward the development of lighter splints with more regard for the preservation of muscle tone and treatment of wounds when they were present. Dr. Mathysen, a Dutch Army medical officer, described the first plaster of paris bandages in 1852. Finely powdered plaster was rubbed into strips of coarse-meshed cotton by hand. These were rolled into bandages. During the Crimean War they were used by both armies though civilian doctors continued to use the starched splint method.

Seventy-five years ago, a plaster of paris jacket was devised for treating Pott's disease. Other substances in use at this time included: gutta-percha, wood, leather, starch, and bandages stiffened with gum, glue, paraffin, and sodium silicate. The latter was painted on to cotton material in layers. It was very slow in drying but it continued to be used as recently as 1914. However, by the turn of this century, plaster of paris was accepted as the best material for casts.

What exactly is plaster of paris? It is the name given to powdered, dehydrated gypsum, the same substance that is being used so extensively today as a form of insulating material in our homes. In the modern preparation of plaster of paris, the gypsum rock is first ground to a powder. This dust is heated in large kettles equipped with agitators. The heat is accurately controlled to avoid too great or too little loss of the water of crystallization. The temperature reaches between 300° and 400° F. The powder is then sifted or screened to remove all lumps and at this time the desired accelerant or a retarding agent may be added. Sodium chloride or gypsum crystals speed up the rate at which the plaster will set. Such substances as animal hair, horny organic material, gelatin, or vinegar

may be added to slow down the hardening process by protective colloidal action.

Certain reactions take place in the media during the setting process. When water is added to pure plaster of paris, gypsum crystals begin to form. During the formation of these crystals, the potential full strength is determined on the basis of the closeness with which the crystals interlock. Crystallization takes from twenty-five to forty minutes and, when it is complete, the mass is said to be "set." It has now attained one-third to one-half of its final strength. Full strength is gained with the drying out of all excess water. This excess works its way through the interspaces of the gypsum crystals and evaporates from the surface of the drying mass in from eight to twenty-four hours, depending on the size of the cast.

The requirements of the best orthopedic plaster of paris are that it shall be 99 per cent or more pure gypsum; that it be very finely ground, flour-like in consistency; that it be pure white in color; and that it be thoroughly mixed so that the setting time will be uniform for the whole cast structure. The plaster of paris bandage is made of crinoline, sized with starch, and thoroughly impregnated with the gypsum. It must be stored in a dry place so that moisture will not be absorbed from the air, prematurely causing crystallization.

MODERN TREATMENT OF FRACTURES

First aid in emergency treatment is designed to control the degree of shock as much as possible and to avoid further injury. To this end, the limb is immobilized by the application of a temporary splint, pending treatment by the physician. Securing the limb in a pillow, firm enough to provide support, is a very satisfactory first aid measure. If it is absolutely essential that the patient be moved before the injured limb has been fixed, adequate support should be given above and below the site of the fracture and traction should be

made in the line of the long axis of the bone to prevent either rotation or an angular motion.

In most cases, some form of anesthesia, either general or local, is given before the fracture is reduced. If a local is ordered, following the work of Bohler, a solution of novocain (20 cc. of 1 or 2%) is injected into the hematoma of the fracture. The area thus becomes anesthetized and the regional muscles relax, allowing manipulation and reduction.

An example of the use of closed reduction might be found in the manipulation, reduction, and application of a plaster cast for a "Colles fracture." This is a fracture of the distal end of the radius. It is usually due to a fall on the outstretched hand, resulting in a backward displacement of the end of the radius. This fracture can be reduced quite easily and the wrist is maintained in position by a cast. In this, as in all cases where casts are applied, we must watch carefully for consequent swelling and discoloration of the extremity.

Some fractures may require weight traction or it may be used for gradual reduction without resorting to the use of anesthetics. Traction may be secured through the use of mole-skin adhesive (humerus), weights and pulley (femur), Kirschner wire traction, etc. Mechanical apparatus when applied to the body requires constant supervision. The points in the nursing care which should receive special observation include:

- (a) That the pull is in the line of the normal bone.
- (b) That the weights hang free.
- (c) That the foot is in balance.
- (d) That the foot is supported properly to prevent foot-drop.
- (e) That the patient has not slid down in the bed thus destroying the effect of the traction.
- (f) That there are no signs of abnormal pressure. Pressure sores may develop in a comparatively short time.

In compound fractures, all traumatized muscle, fascia, and skin edges are excised, blood clots and loose, small fragments of bone removed, and the protruding bone surfaces, which

are contaminated, must be excised. Local anesthetic is not practical for the open reduction of fracture. In some instances it may be necessary to use grafting materials to ensure proper alignment and recovery.

One of the interesting, newer forms of treatment for fracture of the shaft of the femur is the application of the Roger Anderson splint. This utilizes the principle of well-leg traction. Special apparatus is necessary. In this method, skeletal traction is kept constantly applied to the affected limb by means of a Steinmann pin through the distal end of the tibia. At the same time, countertraction is

secured by a pulsion force against the well leg. X-rays of the part are taken to locate the fracture site. The pins are then inserted in the desired direction. A bolt is placed on each pin and then a bar joins the two bolts. By tightening the bolts on the pins and bars, (after x-rays show them to be correctly placed), the apparatus is kept in the desired position. Advantages of this form of treatment are: immediate ambulation, painless convalescence, good end-to-end reductions, patients may be more fully clothed, minimum hospitalization. However, the closest watch must be kept for pressure on the well foot.

The Nurse and the Social Revolution

CHARLOTTE WHITTON, M.A., LL.D.

Average reading time — 27 min. 48 sec.

THERE CAN now be little question that the years from 1914 to the present have marked a change and shift in the structure of society, as tremendous in its upheaval and subsidence as those which marked the evolution and decay of feudalism, the growth of the mercantile and commercial society which followed upon it, and the subsequent domination of the forces emerging in the industrial revolution. These years, to which most of our present generation belong, will likely be described as "the era of the collectivist revolution." We have not yet lived through these changes to the end; in fact, in these very months we are "being swept into the centre of a constitutional vortex of which no one at present can see the result: the age-long question, marked by a new intensity, of the relation between government and individual and particularly between the government as employer and those whom it employs."

Mass planning, mass organization are characteristic of the modern industrial and urban economy and it is one of the tragedies of a dwindling

democracy that the problems, created in such a society, call for comparable methods to meet them. Men look to the state to become the dominant agency in life. Not the community as a spontaneous and vital entity but the community's organized administration tends to become the responsible thinking, planning, and determining power, assuming, dictating, and discharging more and more of the functions which the individual formerly exercised on his own or in free and co-operative enterprise.

SERVICES MUST BE PAID FOR

One of the editorial staff of *The Economist*, friendly and forward looking in the development of modern social services to reinforce living in this massive modern state, warns, however:

A country can have only the standard of living it can pay for; and the standard of living includes the National Health Service as one of its components but only one and not one with an overriding priority.

It is often argued that a health service will increase the national income

because it will bring better health to the workers with a consequent increase in their productivity. But the argument is just the same for all the social services. Workers will produce more if they are better educated, if they have more security, more comfortable houses, cheaper food, and the prospect of an adequate pension on retirement. Some of this may be true—in the very long run. In the short run, there is no escaping the fact that the social services have to be paid for, out of taxation, in one form or another.³

These relationships should not be left out of any responsible discussion of any welfare provisions, nor should some appraisal of the background in which any specific scheme or service is set.

THE CANADIAN SETTING

Our background is Canada, at the mid-century 1949-50. Youngest of the really new states of western civilization in this era of sudden and sweeping change, Canada is, in some respects, fortunate, in others unfortunate, because of that fact. She is fortunate in that the mould of her social structure has not yet been fully and firmly set and, therefore, is flexible enough for adaptation. She is unfortunate in that, thus early in her growth, she is faced with the challenge of adjustments which are shaking older, wealthier states to their very foundations.

The Canada of 1900 and the Canada of 1950 contrast sharply even in their physical setting. Of course, with the adhesion of Newfoundland, we extend to the very rim of the Northeast or the Northwest Atlantic (it depends on your point of view). The distribution of population, and so of development and influence within the country itself, has significantly altered. In 1900, the median of population was about Ottawa, for only 350,000 people—about 7 per cent of the population—then dwelt west of Ontario. Now a third of our people dwell there and the central line of Canada's settlement runs near Sault Ste. Marie.

Canada was predominantly rural:

6 out of 10 people lived in the country districts. There were only two cities — Montreal and Toronto — over 100,000 in population. Manufacturing, trade, and finance were concentrated in a few eastern centres and our production turned on a few staple lines. The development of hydro-electric power was beginning, but the railways, even the C.P.R.'s western lines not yet of age, were supreme in transport. A few automobiles moved in short, slow, dangerous range along roadways built for heavy horse-drawn drays and were rarely risked by "the carriage trade." This was typical of the whole tempo of life.

Now, only 45 per cent of Canadians are left dwelling in rural areas and not all of them are in agriculture. It engages but 30 per cent of our people today. Only 3 per cent are in forestry and fishing, about 2 per cent in mining. Manufacturing takes almost a quarter of them (23 per cent) and trade and finance, 13 per cent. Personal service—that is, hotel management, restaurants, catering, etc.—holds about 8 or 9 per cent; the professions, 6 to 7 per cent; transportation and communication: telegraph, radio, and water, road, rail, and air transport, about 2 per cent; construction, 5 per cent, and the public service, at dominion, provincial, and municipal levels, 4 per cent.

The setting of Canadian living has also shifted—practically one out of every four Canadians now lives in one of the nine cities over 100,000 in population and another 15 per cent in those between 10,000 and 40,000. We have now essentially the same number of people living in our towns and cities over 5,000 as in all our rural areas, and this population is spread over an area vaster than the United States or the continent of Europe.

Consequently, we must work out ways and institutions of living to serve populations and living conditions as industrial, urban, and complex as those of the teeming cities of these continents and, at one and the same time, provide for life and economies as primitive as their poorest

frontier areas. We must do all this with a population less than that of New York State or the metropolitan London area. Surely, never in social history, was a problem so complex, posed to so few people of such diverse strains and occupations in a territory so vast and with resources so great but presently so slight and difficult of development as Canada's.

THE BRITISH WARNING

British experience of recent months, in the health and social services, seems to establish one warning beyond dispute, and one that is applicable whether the economy be capitalist, collectivist, or communist. It is that we must know well and perceive clearly certain specific relationships—the assessment of the resources, no less than the needs, of the community we would serve; and of its capacity, in both income and man- and woman-power no less than technical facilities, to sustain the program and mechanisms, designed for the greater well-being of a greater number of its people.

The nature and extent of the problem of health care for any given unit of people must be seen against this broader background of the particular community—be it nation or city, town or rural area—its resources and the nature and activities of its people, and the whole intricate question of all its human needs, welfare, and education, no less than health.

Within the specific health sector again there must be this integrated approach with awareness always of all elements therein—the community, the over-all community services, the clerical and teaching centres, the hospitals and the healing professions and personnel.

HEALTH SERVICE NOT INSURANCE

It is of major importance to emphasize that health insurance concerns the nurse little if at all. To quote the official British publication, *The National Health Service*:

The health service is quite separate from the insurance scheme, which exists to give people not medical care but

money during sickness and unemployment, and to provide pensions.²

It is a state health service, covering the entire population, into which the United Kingdom and Scotland have been, even its proponents must admit, too precipitately plunged. But it is health service, not health insurance. The insurance deductions of employer and wage-earner, under the old health insurance plan, provide one dollar out of every nine; the other eight dollars come from taxes of the central and municipal government.

Even if Canada hesitates to risk a state health service, health service as a public utility is already far on its way through the numerous prepayment plans of government and private employers and through the personal underwriting by tens of thousands of their hospital and medical care. The integration of all these schemes and of the resources to meet them, and of their extension to include due provision for nursing, dental, ophthalmic, and pharmaceutical needs, is coming as surely as day follows night. The costs and mechanisms may be adjusted as between public and private enterprise and responsibilities, but pooled health service is taking firmer shape and larger form daily.

The present Canadian health service planning is sound in that we are making haste slowly by careful survey and study, through the provinces, of the proper agencies of administration. A representative British medical leader writes:

The scheme embodied in the Act is, on the whole, a good one and was desired by a majority of the public; but to launch so comprehensive a scheme in such haste was asking for trouble . . . The basic defect lies in the fact that too many people require the services of too few people.³

We may avoid this situation if we advance slowly by evolution, not revolution.

THE RANGE OF HEALTH SERVICES

It is 560 years since the first health measures were passed in England—a statute of Richard II, enacted in 1388, prohibiting the pollution of

rivers, ditches, and open spaces. It is just 100 years since the first use of the term "public health" appeared in a British statute in the Act of that name, introduced by Lord Morpeth in 1848.

Provision for the health of all the people still begins on this wide periphery of positive approach in education and protection. The defences reach far out—the sites of communities, their drainage, water supply and sewage disposal; their housing provisions; their safeguards and controls over the factories, shops, and offices where people work; the centres in which they gather for food, recreation, worship. Consequently, in this first trench, broad and effective liaison must exist between the central and the municipal authorities, and among the officials and services, planning and administering public works, and supervising building permits, the architectural and construction personnel in the community, both public and private; the authorities licensing and inspecting market, business, commercial, and industrial facilities, and supervising play and recreation centres and public gathering places. The operating personnel will be drawn from ranks of the engineering profession and from the medical profession but before and beside both, as educator of the public, as visitor and as inspector, will be found—the public health nurse.

Our enlarging knowledge of what contributes to good health, and what constitutes hazards to it, dictates the second line of defence, also well out in the community—in industrial and occupational health services, in the prevention and control of communicable disease, and in the positive care and education of the infant, pre- and school age child and student. Here the responsibility is of a threefold nature—preventive service, again; health education, public and personal, and actual treatment, both of a protective nature, as in vaccination and immunization; and curative in the correction of such conditions as malnourishment, remedial defect, etc.

Here the function of education, health examination and supervision, and medical care meet; here industry, business and labor personnel, the educational and health authorities and, of course, the parent in the home, all meet. But, again, a constant factor in all areas of activity and service is the public health nurse.

Closely related comes yet a third line of inner defences, fighting when disease, sickness, ill health, or injury have already breached the wall—the clinics of health centre or hospital and the nursing service in the home of the person under care. The stronger and more skilled the personnel, the more adequate these resources, the less the cost in disruption of occupation, earnings, and home life, and in readjustment for the individual in his setting; the greater the volume of treatment and care in that setting, the smaller the recourse to the more costly care of hospital, sanatoria, or other custodial unit.

Here, the extending resources of medical science come into play in assurance of diagnostic, radiological, and pathological service, available to practitioner, hospital, and patient alike. Here the efficacy of personal instruction of the patient, the practicality or risk of treatment by his or her family, at home, turn upon the availability and efficiency of capable clinical and home visiting nursing staff. And here, more probably than in any other one focus in any plan of health care for the people for the relation and reconciliation of the personal interests of the patient, the private practitioner and the personnel of the public service are affected. Here is that vital link, with the setting behind the patient and its relationship to his mental and spiritual, no less than to his physical well-being, strengthened or broken.

The holding of the last outer trench, as it were, of treatment of the potential or the convalescent patient, in his natural setting, turns in large part upon the linking in of bedside nursing service, preferably on an hourly and community bureau basis. But it turns, also, on integration with

two other auxiliary resources—the *nursing subaltern*, who can be used for much of the home nursing and minor nursing routines from which the fully qualified nurse could be freed to the greater use of her greater skills; and the *domestic aide*, to whom the household responsibilities can be allocated to permit the ordinary life of the patient's home to carry on with the least possible disruption, whether she be there or under custodial care which would be hampered in effectiveness by worry or concern over the home situation. The easing of that anxiety may involve economic aid or welfare service in the home. It may mean assurance of care there or elsewhere for dependents. It may mean all or any of those racking worries that, added to the worry of the illness itself, easily overwhelm patient or family or both. Here there must be the most concentrated liaison among the personal physician and the clinical centre, the community's full resources in welfare and auxiliary services, and, of course, the patient and his family. And, at its centre, is the nursing service, on duty in the clinic and in the home and again the least common—and so often how "least"—denominator of them all.

When the need cannot be held at this last outer defence and the patient enters custodial care of hospital, sanatorium, mental institution, or unit for the care of the chronic or convalescent sufferer, the custodial responsibility breaks into three areas—general business administration and management, including the operation of the unit, in a sense as a hotel providing shelter and food; medical treatment; and nursing care. Not the least of these and the very core of any good hospitalization is good nursing.

THE PLACE OF NURSING

The costliest elements in the health defences are presently two—medical care and hospitalization. They, along, of course, with dental, ophthalmic, and pharmaceutical services, can be the making or breaking of any health service, maintained from and ac-

cessible to the entire community. The extent to which they can both be conserved depends, more than on any other single factor, on the assurance of a sufficient supply of adequately trained nursing personnel. That supply is neither now nor potentially adequate, nor are the training resources and procedures, now available in either nursing, welfare, or auxiliary services, fully geared to the changed and varied demands that will be exacted from this nursing and auxiliary personnel in the rapidly extending services under the Dominion Health Service plan. This, in turn, is affording the substructure for the extension of health services to the Canadian people, on a public utility basis, comparable to the educational services. Its maturing can be retarded by years, its costs made practical or impossible as this problem of the amalgam of the whole—the nursing and auxiliary personnel—is imaginatively dealt with or neglected.

The place and responsibility which nursing thus assumes even in the present, but, more so, in the presently emerging health services of the people, throw upon the profession the problem of assuring as wide a variety of specialists, consultants, administrators, and general practitioners as ever confused the senior profession.

The most broadly dispersed, the most intimately delicate in the difficulty of adjustment will be the age-old function of the actual nursing of the sick, whether in domiciliary or custodial care. The setting may change and private nursing, in the sense of the individual nurse working on her own personal retainer, will probably shrink, as has private medical practice already in Britain, to not more than 5 or at most 10 per cent of the whole. Personal, private duty nursing will continue, concentrated on the really ill, whether the nurse works on a daily or hourly basis, on her own, or as personnel of the bedside nursing unit—voluntary or statutory or a blend of both.

Personal nursing will continue to demand heavy personnel on a full-

time basis, in clinical and public health services, but will alternate, to greater degree, with patient and community service, both in domiciliary and custodial care. This will call for a "blend" in nursing personnel, capable both of nursing and of instructing children and adults in positive health, of moving in and out of the occupational clinics and services, dispersed (to save time in transport and absence from work for both patient and health personnel) through both rural and industrial areas. The educational authorities, from kindergarten to university, will want the public health instructor nurse.

Because of the practical problems of population, distance, and finance, certainly in Canada, somewhere along the line, at this level of actual service in the patients' own setting, liaison personnel will have to be evolved in which a "hybrid" may have to be considered. What seems outlined is a nurse who will be in part a welfare worker and a welfare worker who will have some elementary first aid and public health knowledge. Both of these people will be sufficiently aware of the intricacies of each other's fields to act as registrars to refer the problems of major import to the respective agency of major practice.

Both within these ranks of what might be called the "mobile nurse" and in custodial units, there will be an even more insistent demand than now for the nurse with administrative and executive ability for staffing the general mechanism of the nursing resources of over-all health services, and for the specific supervision of technical and personal nursing service within clinical, domiciliary, and custodial units. These "executive" or "administrative" nurses will be required at the very highest levels of the governing bodies and authorities, no less than in the actual operating units of the health services. At the very cog of the mechanism will be the personnel assuring the preparation and the continuous "refresher" instruction of those who staff such vital and varied services. The processes of nurse training and education are

already faced with almost paralyzing problems in assuring personnel, adequate in preparation and numbers, for these different types of nursing service and, most difficult of all, of personnel, interchangeable among them or sufficiently "multilateral," to combine, as will be necessary in so many areas in Canada, more than one of these responsibilities and services.

THE SUPPLY

The "nursing gap" seems to be showing less promise of closing than the dollar gap and is concerning the same nations. The United Kingdom needs 125,000 nurses and is 45,000 short; the United States, with 318,000 nurses, still has 33,000 hospital beds closed due to the shortage. In 1948 it imported 779 nurses from Canada, a number equivalent to nearly 20 per cent of the total number of graduates of that year.

In general hospitalization in Canada, in the last eight years for which statistics are available, the number of patients increased by 70 per cent, the enrolment of student nurses by only 45 per cent. A study made by the Mental Health Division of the Department of National Health and Welfare indicated an increase of 50 per cent in the number of patients in mental, tuberculosis, and chronic care units in the same period in which the number of registered nurses therein decreased by 200, the non-registered by 400. The National Health Survey of 1943 revealed, in spite of a 28 per cent increase in nurses in four years, a shortage of 4,400, excluding private duty and industrial work. By 1946, the Canadian Nurses' Association studies revealed an overall shortage of 8,700—7,000 hospital nurses, 1,200 private duty, 500 public health nurses.

Ontario is the best served in nurses of all the provinces, yet, excluding public health, private duty, and industrial nursing, the last reports indicated a shortage of over 1,000 graduate nurses and over 400 other nursing personnel.

The Canadian Public Health Asso-

ciation reported to the Dominion Council of Health in 1946:

The greatest deterrent to the expansion of public health services in Canada at the present time is the lack of trained public health nurses. Existing public health agencies are expanding and new ones are being planned all across Canada, but in most cases these programs are being retarded drastically because authorities are unable to find public health nursing personnel.

Canada's nursing force, at the present time, is about 31,000 active nurses on the registers (with another 7,200 still registered but not active). There are approximately 13,000 student nurses in the hospitals and 10,000 auxiliary nursing personnel. With the target of one nurse for 280 of the population, Canada would need 15,000 more nurses in the next 10 years.

The hospital beds already contracted for, under the Dominion Health Plan, number 15,028, which, when they are finished, will demand 2,700 more graduate nurses and 1,700 auxiliary personnel.

The highest number of nurses on record graduated in 1948—3,991. The net "loss" a year in the profession through marriage, transfers to other work (to which one in 14 nurses go), etc., runs about 2,500, so a graduating total of nearly 4,000 represents a relatively small net gain. Consequently, the situation shows a definite worsening in supply and, at the present rate of graduation and replacement, a continuing problem and a persisting shortage which, even by 1960, will still approximate 7,000.

TRAINING

The problem is, in part, one of *training*, of arduous work, of long hours, comparatively poor remuneration and uncertainty of employment. This is being vigorously explored in the improvement of existing schools of nursing, and in the significant experiment in Canada on the organization of nursing education, apart from hospital administration and on a par with medical, dental, legal, and teaching training.

The problem is perhaps equally one of *supply*. What is becoming increasingly and disturbingly evident is that there are simply not enough girls and young women in Canada "to go round" in all the tasks which the highly organized industrial and urban economy is asking of them.

There is a disturbing shortage of teachers, of whom over 70 per cent are women. To meet arrears and effective demands, about 7,500 a year are now required. Social workers are in short supply; so are first-rate secretarial, stenographic, and clerical workers, and women for executive and managerial posts in all pursuits.

There are only about 250,000 girls, over 16 years of age, going through school in any one year. All recruits for all the work which women do in this nation must come from that pool. If we are going to retain anything like our present social balances, we have to keep 150,000 to 175,000 for marriage, another 20,000 to help in their own farm homes, some 25,000 to assure carrying on household service in hotels, restaurants, catering establishments, etc., even if they flee the private home. The factories want at least 15,000 new young workers continuously, the offices a similar number; governments, at all levels, seek about 10,000 new girl workers a year; trade and commerce would like the same number; other miscellaneous activities, 7,000 or 8,000, teaching 7,500 and nursing not less than 1,500 net increase, which means about 5,000 new entries a year. Add it up and it's insoluble; there just aren't enough women coming on.

If we take the small number proceeding to matriculation grades—47,000 to 48,000—and try to assign them to the pursuits, desiring this admission standard, the problem is even more disconcerting.

RE-ORGANIZATION OF NURSING PRACTICE

So, quite apart from the content of training, does this problem of potential supply, along with the indication of the many and varied duties of the nursing personnel in the health

services of a changed social structure, not raise yet another question? Perhaps the solution may lie in larger part in yet another line of exploration already under experiment.

Already 12 schools, in all the provinces but Nova Scotia, are training nursing aides to provide auxiliary personnel, though with a registration of only about 1,000. This represents an effort to free nursing of what is not nursing.

Has enough attention been given to the "job analysis" of nursing—present and future?

Is a re-allocation possible of some of the duties, traditionally assumed by the "all-round" nurse in hospital, clinic, and home? Do the executive functions, opening in the health centres especially, not mean an increase in responsibility and status of some of the categories of nursing?

On the other hand, do the integrated services about the patient in the home, and the extent of clinic and centre work visualized, not suggest the creation of more auxiliary personnel of *nursing subalterns* to take over clerical, laboratory, routine, and comparable duties in clinic and hospital, and of yet another corps to act as *domestic aides*, releasing the trained nurse for nursing?

THE CHALLENGE

In the present and prospective functions which the public asks nursing to assume in a changing society there is a challenge of broad and difficult implication. *If the profession fails to meet and master it, solution will come from others, for neither the mood nor patience of the present times brooks much loitering.*

What a philosophical country physician in Britain recently said of his profession applies, comparably, to the closely allied one of nursing:

A profession to whom clinical freedom is its life blood, and which knows better than any the strange particularity of every individual, has suddenly been brought under the control of a single Minister and face to face with an ideology that seeks to attain that all should be treated alike.³

A WORKING PARTY

Is it not urgent for the leaders of Canadian nursing to depart from their traditional secondary position of observing and reporting, leaving the diagnosis to their elders, the physicians, and to take the initiative themselves? That initiative might focus on a quite possible objective. It would be nothing less than the organization of a "Working Party," chaired by one of nursing's own ablest members but drawn also, on nursing's own selection, from representatives of the public, who want nursing, and from the allied groups with whom the nurse's work is primarily done—the medical profession and the governing bodies in hospital and municipal administration.

For that Working Party, I suggest that nursing seek official recognition but quite independent financing and, to it, I further suggest that the nursing group grant the broadest possible scope of inquiry and discretion with the overall instruction to report in the interests not only of the nursing profession and its specific place and powers in the responsibilities of this rapidly changing structure of the care of the people's health, but also in the relationship of nursing care to the general setting and, what the nurse has so long and faithfully perceived and practised, to the greatest well-being of the patient.

And nursing will find, as a profession, as nurses long have personally, that the public will give the nurse and nursing its confidence, its co-operation, and its gratitude.

One of the wisest of England's town practitioners recently wrote:

Every school boy knows that Canute demonstrated that you cannot stop the tide. Much as many of us dislike the idea, we must realize that the tide of human thought is now in full flood towards collectivism. We cannot arrest that tide, but we can try to direct it into channels that will allow time for the harnessing of its energy to the betterment and not, as it is threatening at the moment, to the destruction of all those higher attributes which in the past have contributed so much towards the welfare of humanity.

... The present is the workshop in which the future is being made.³

Yours it is, from your knowledge and experience, to attempt to direct and harness these new currents while there is yet time, for—

*The Moving Finger writes; and, having writ,
Moves on: nor all your Piety nor Wit*

*Shall lure it back to cancel half a Line,
Nor all your Tears wash out a Word of it.*

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Magic and Medicine

L. BLAKE DUFF

Average reading time — 4 min. 24 sec.

IF WE COULD take the very earliest view it is in a cave in the Pyrenees, a picture there on the rock wall, drawn by an artist of 15,000 years ago—portrait of a doctor. This medico, dressed in animal skins, had his own skin painted and he wore antlers for head-gear. His skills, one may well guess, lay in his ability to scare off or destroy the evil beings who lurked in sun and moon, in the clouds and skies, and in the winds and rain, in the streams and trees, and in other people. Disease was magical; the cure, too, had to be magical. When science began its war against incantation and charm, magic and superstition, is not known but we do know the fight is on yet. Gradually and painfully to this date science has won its way. It still has miles to go.

In 1878 the German, Georg Ebers, found in Thebes the oldest complete book known to man. Because of its unique position in the chronology of books it is famous among bookmen. But it is famous on another score for it is a compendium of all the medical knowledge of Egypt 35 centuries ago. While it is a medical book it is very wide and generous in its scope—telling what to do about mice and lice, falling arches and bald heads. You will find old friends there, like pyorrhea, tumors, and fevers; old remedies like mustard, castor oil, and hartshorn. *For baldness*: rub the head with a mixture made up of fats from the hippopotamus, lion, croco-

dile, and the goose. (Something very appropriate about the goose being in there!) *For an infected eye*: Take half a human brain, mix it with honey, and anoint the eye.

Disease was here on this earth waiting for the arrival of man. To confront it man had only such silly and futile weapons that he was helpless in trying to meet the challenge of his greatest enemy. This continued to be so for long centuries after the Ebers papyrus. The Black Death of 600 years ago was the greatest catastrophe the human race ever endured. It reached every corner of the known world. Nearly half the population perished in swift and horribly painful death. The Black Death destroyed a larger proportion of the population of every European city than the atom bomb killed at Hiroshima.

Plagues followed plagues, cities were devastated again and again, as London in 1665, Philadelphia at the break of the last century, and our own cities in eastern Canada in 1834.

The march of time had to come right down to our own era before it was realized that these scourges came not from a malignant god, but from ignorance. It took all the countless ages to learn that disease came with dirt and filth, that it was spread by uncleanness, by the fly, the flea and the mosquito, the mouse and the rat; that the best passport to good health was clean water, clean

milk, and clean food. It is not so many years ago that every hotel washroom in Ontario had a roller towel and a chain comb. Now not one could be found! Where is the common drinking cup? Its era seems as far away as that of Nineveh and Tyre yet the man who inaugurated the campaign to abolish the common drinking cup from the face of the earth is still living.

We talk so much about the good old days. There never were any. These are the best days ever. Dr. J. J. Talman, a few years ago, by means of church registers, newspapers, and gravestones made a study of deaths in the 1820's in the Niagara Peninsula. He found that the average age at death of all the persons listed was 25 years. Rural Ireland, twenty years later, had an average of 19. Four hundred years ago the average life expectancy was 8 years; now it is crowding 70 years.

Medical science can well say of itself, "I am the strongest force operating in modern civilization toward human betterment." That is a tremendous thing to say, but it is true.

The first man licensed to practise medicine in Ontario was John Gilchrist. He walked 70 miles from Cobourg to Toronto to be examined by the Medical Board. That was in 1819. But we had doctors before that, wherever they came from and whatever equipment they had for practice. John Strachan (later Bishop), writing in the *Kingston Gazette* in 1814, said of doctors:

They comprehend not the causes or nature of diseases; are totally ignorant of anatomy, chemistry, and botany. These are men who have never been regularly taught. They are, indeed, so unschooled as to be unable to read the books on medicine and surgery.

It may seem a bit odd that the great place in literature is held not by the preacher, the teacher, or the lawyer, but by the doctor. The father of all French writing was François Rabelais, whereas in English we go back to St. Thomas Browne with his "Hydriotaphia" and "Gardens of Cyrus" and Robert Burton with his monumental "Anatomy of Melancholy." These are works that belong in the great stream of English literature that began with Chaucer of "The Traveller" and Goldsmith, of "The Deserted Village." Tobias Smollett of "Humphrey Clinker" and "Peregrine Pickle" were forerunners of Keats and Shelley who walked the hospitals of London. In our own time among these doctor-writers we have Anton Chekov, Axel Munthe, and Conan Doyle. One of the greatest was, of course, Sir William Osler, great in his profession, great as a bookman—a curator of the Bodleian library, a delegate to the Oxford University Press, and president of the Bibliographical Society. Nor could I close on a better note than a quotation from Osler:

*For yesterday is but a dream
And tomorrow is only a vision;
But today well-lived makes
Every yesterday a dream of happiness
And every tomorrow a vision of hope.*

National Health Week

Dr. E. A. Hardy, secretary of the National Health Week Committee of the Health League of Canada, has issued an appeal to national, provincial, and local organizations to co-operate during Canada's forthcoming 6th annual National Health Week, scheduled for January 29 to February 4.

"National Health Week is sponsored by the Health League in official co-operation

with Departments of Health and Departments of Education," said Dr. Hardy, "but its success will be made possible only through the support of the nation's numerous public-spirited organizations, such as service clubs, women's groups, and other professional and voluntary societies." We hope that nurses will give their full support to this worthwhile project.

R.C.N. Civilian Health Department

NORAH K. CORNWALL

Average reading time — 10 min. 24 sec.

YOU AND I, standing on the shore of some great body of water and looking at a graceful ship gliding along, destined perhaps for some far-away land, seldom think of the hundreds of pairs of human hands that have worked night and day creating, assembling, and testing the many parts, until finally, after long months and sometimes years, she slips down into the water for her official launching and trial run. This is only the beginning of a ship's life. There is the tremendous task of keeping her in shipshape. It is in our dockyards where this is done.

In the naval dockyard at Esquimalt, B.C., ships of the Royal Canadian Navy, as well as other ships of many nations, find a sanctuary for rest and recuperation following their sometimes turbulent trips across the mighty Pacific. Employed here are hundreds of people, both men and women, in many and varied occupations. There are university graduates and tradesmen—stenographers, messengers, postal officials, clerks, highly skilled technicians, electricians, storemen, executives, gardeners, mechanics, canteen attendants, cooks, signal specialists, draftsmen, carpenters, plumbers, janitors, chauffeurs, engineers, and many others. It is like a small city, only four miles from Victoria. About a mile away by land and half a mile by water is the Naval Barracks, where the actual training of our present and future naval personnel takes place.

In the spring of 1944, I was asked to open a new department in the naval dockyard—a health department to service some thirty-two hundred civilians employed in two of our West Coast naval establishments. There is always something tremendously exhilarating about pioneering, whatever field of endeavor it may be in. And so, with six years of varied experience in several fields of nursing behind me,

I launched forth upon what seemed at first to be an almost hopeless task. I wondered many times whether we were going to be able to succeed against the tide of traditions which had to be broken down, volumes of outdated rules and regulations to be dealt with. Heretofore I had always nursed in surroundings which had been ready made. Now there was a three-roomed, very old, red brick building which I was told might be used "providing a naval department did not want it." To the average navy man, a civilian employed in a naval establishment was someone to be tolerated but that is all. It made no difference that many of these same civilians were retired navy men—some with distinguished service records, some with twenty years of service behind them.

The formative period was spent in assembling medical and surgical requisites as well as furnishings and other necessities. Ordering anything in a government establishment is not like buying from a store. For every article desired, from a pen-nib to an operating-table, one must make seven copies of the requisition and have it authorized by two and sometimes three signatures. It must then be registered, stamped, and finally submitted to the department where you hope you may find it. If you are lucky, you receive said article, in whole or in part, in anywhere from two weeks to two months. Occasionally the article in question is not approved, or is not in stock, in which case it has to be ordered from an outside source. Sometimes NSHQ, Ottawa, must be approached before approval or disapproval is granted. As the health department was a new departure, almost everything one was used to working with seemed to be unauthorized. This has been amended since, after five years of existence, we now are an established department.

Then there was the question of furnishings. Fortunately, Providence came to my rescue in the form of a dear old gentleman who had served under five sovereigns and was still serving as best he could. He knew all about everything, it seemed. Between us we unearthed some furniture from a store-room which had originally been used on ships which had been converted into warships. I found someone else who had been an upholsterer and, with the help of the carpenters, painters, plumbers, electricians, and a gem of a janitor, we finally were able to open the doors of a rather strange health department. It was then June, 1944.

Not knowing exactly what type of patient would pass through our doors, one had to prepare for almost every type of emergency. Having no doctor to call upon for assistance, the initial stock of medical and surgical requisites had to be only those which a graduate nurse was authorized to use, without the aid of prescriptions and doctors' orders. Little by little the clinic grew to meet the needs as they presented themselves. It was a wonderful experience. Many times I have blessed my very strict supervisors for their rigid and thorough training.

During the war, when the refitting of ships had to be done at top speed, we experienced many severe accidents. Now the pace is slower, our safety department is very active, and the prevention side of the ledger is more heavily balanced than formerly. We have tried to make our personnel health and accident-prevention conscious through organized classes in first aid, and by safety supervision and follow-up work.

In 1944, our staff consisted of one registered nurse and a janitor. In 1945, a small unit was opened to service men employed in our Naval Armament Depot, boiler and machine shops. A first aid attendant was installed here. He was an ex-naval sick bay attendant, a registered pharmacist, and a St. John Ambulance industrial certificate holder—a most valuable person. A year later, an-

other unit was opened at Kamloops, B.C., where a R.C.N. Ammunition Depot is located. A graduate nurse with excellent clinical experience was employed here. The following year a similar department was opened at *H.M.C.S. Naden*, our naval barracks where a fair number of civilians were also employed. A graduate nurse was engaged to administer this. Six months later another ex-naval nursing sister was engaged to set up and operate a similar department at *H.M.C.S. Royal Roads*, then a college for naval cadets, now a combined services college.

Our duties have gradually become standardized, as well as our equipment. Our patients are our friends. We are all Dominion Government employees working in his or her particular branch. I think that is one reason why it is all so enjoyable. Our duties include:

- (a) Maintenance of equipment and supplies; (b) ordering and replenishment of same; (c) first aid to all accidents and illnesses, both major and minor; (d) proper reference to outside doctors, of patient's own choice, where indicated; (e) making out and submitting compensation forms and accident and illness weekly and monthly summary sheets; (f) keeping of personal record cards in a filing system; (g) treatments given include: dressings, aural syringes, eye baths, removal of foreign bodies, massage, fomentations, poultices, medications (within nurses' jurisdiction) for rhinitis, headaches, and other disorders; (h) co-operation with outside doctors in administration of prescribed drugs, serums; removal of sutures, dressings, etc.; (i) social service advice to employees for families, with referral to proper civic and provincial agencies, consent having been obtained beforehand from employee; (j) public health of canteens which are periodically examined; (k) pre-employment and biannual physical examination arranged for all food-handlers, including chest x-ray and Kahn test; (l) arrangements made by telephone for (1) transportation of severely injured to local hospitals or doctors' offices, (2) dental appointments, (3) medical appointments; (m) welfare extended to tempo-

rary indispositions, thus minimizing lost time; (n) making and referring for sterilization dressings and other surgical requisites.

In 1946, a Royal Canadian Naval Well-Baby Clinic was established on the West Coast. As no other building was available at the time, our space was used for this, with clinics twice a week. The nursing sister who established this was a graduate of the Hospital for Sick Children, Toronto. We had a wonderful year together, doing the type of work we both loved. Soon, however, the baby clinic became too large and required its own quarters. It is now considered the largest well-baby clinic on the West Coast.

For grave emergencies the services of the R.C.N. medical officers are available. The Motor Transport Department is prepared at all times to transport seriously ill and injured persons to the city hospitals. This transport service is also given in minor conditions which might be aggravated by a public conveyance. Ambulances and cars are both at our disposal, if necessary.

In the five years since our beginning we have also assisted the provincial tuberculosis unit in conducting its chest x-ray surveys when their van visits naval establishments. Almost all our employees have taken advantage of this service.

A blood donor service was established to assist our employees and members of their immediate families when transfusions were indicated. For this a voluntary blood grouping survey was conducted with a most gratifying response. Volunteers were transported to and from the local hospitals without loss of pay. Since the establishment of the Red Cross blood banks this is no longer in operation.

Occasionally our patients come to us with problems which they have been harboring for years, which they have been perhaps afraid to report to a doctor. Sometimes we are able to detect symptoms which are indicative of future serious troubles and can

explain to them how very important it is to have these things attended to in order to ensure them of a longer, healthier, and happier life. It is wonderful how they respond to advice and permit us to make the necessary appointments. Sometimes operative procedures have been necessary.

Family problems are often much easier to shoulder by talking them over with someone who can help. Perhaps a mother of a family becomes ill and must go to hospital. By arranging an interview with the Red Cross Home Service, someone suitable will be engaged to live in the home and keep everything running smoothly until the mother's period of hospitalization and convalescence is over. In this way no schooling is missed; father is able to continue in his daily work; bills can be met and no further burdens are added.

What the future of our department will be we do not know. We are all aware that "once an organization rests on its laurels it is finished." There is much to be done. There are plans for a much broader health scheme which as yet we have not been able to put into effect. Our proposed program would necessitate the services of a doctor who could conduct, with our assistance, a preventive and corrective health plan for all, including compulsory physical examinations for every employee and prospective employee.

This is our story. From my little building, over which a Red Cross flag flies, one can see many of the ships of the Royal Canadian Navy which are based on the West Coast. Destroyers, cruisers, frigates, minesweepers, mine-layers, corvettes, and small harborcraft—all are tied up alongside one of the many jetties. Each in turn may leave and not return for several days, weeks, or months. Where they go and what they do is a naval operation, just as important in peacetime as it is in time of war. These are the ships we are servicing. In turn we feel we are serving our country and the principles of freedom Canada stands for.

No woman ever found success at the bargain counter.

Institutional Nursing

Color, Line, and Balance

SISTER FRANCES LOYOLA, B.Sc. (H.Ec.)

Average reading time — 8 min. 48 sec.

"O BEAUTY, ever ancient, ever new," cried the fourth-century Saint Augustine to his Creator. Deep in the heart of every human is a longing for beauty, for loveliness—reflections, however faint, of God who is Infinite Beauty. How pathetically this is sometimes evidenced as when we find in a slum district a tin-canned geranium on a narrow window-ledge, cherished and nurtured for the sake of its brave, bright bloom.

The institutional nurse who endeavors to beautify the hospital not only satisfies her own innate cravings but is doing something worthwhile for her patients. Rest is one of the essentials in hospital therapy. Acoustical treatments and other devices aim at promoting this so-necessary rest through quiet; the simplicity of true beauty rests the eye, the mind, and the whole being.

We have gathered here a few fundamental principles that may be helpful to those who are but making acquaintance with the intriguing, if somewhat puzzling, problems of interior decorating—an amateur speaks to other amateurs.

Gone is the era when it was considered necessary to have everything in the hospital glaringly white. But in the application of color only very great artists may trust to intuition. Fortunately, there are guiding principles to aid the rest of us.

The exposure of a room, its purpose, and its size have a bearing on selection of colors. Sunny rooms ask for a background of cool colors; rooms lacking sunlight call for warm

colors. Reds, oranges, and yellows are warm colors; rose, ivory, buff, pink, coral, brown are warm tones. Similarly grey, violet, and greens have the same cool feeling as blue. Color scheme examples are:

NORTH ROOM: Color theme, *red*—pink walls, chintz in the whole scale of reds from deepest wine to palest pink, mahogany furniture. Cool touches for relief may be in complementary color, deep green, with white accessories.

SOUTH ROOM: Color theme, *green*—a cool quiet color. Nature mixes green most successfully so we can use varying shades and tints of green with warmer notes to relieve them—honey-toned, blond furniture, gold foil lampshade, and chartreuse accessories, all off-shades of yellow. Draperies may be of striped materials combining green, yellow, and brown.

EAST ROOM: Color theme, *medium yellow*—used in walls, draperies, and blinds, it maintains a feeling of sunlight long after the sun has left. With yellow use a 50-50 color plan—some warm, some cool; red, giving strong warm accents; pale green, definitely cool.

WEST ROOM: Getting strong sunlight in the afternoon will be pleasing in *cool blue* with warmer yellow and brown to complete combination. Neutral grey may tie warm and cool colors together.

To balance colors we are advised to use three major colors, giving the small proportions to the most brilliant color—e.g., 50 per cent grey, 30 per cent yellow, 20 per cent red. Although other colors may be present they should appear only as soft, subtle undertones. "All colors are harmonious if used in the right proportions" is an oft-repeated dictum in decorating classes. What artistry there is in a mixed bouquet of garden flowers!

Sister Loyola hails from Charlotte-town, P.E.I.

Good colors are clean and clear; bad colors are muddy and vague. "Avoid drabness in your color scheme," writes Christine Holbrook. "Don't choose lifeless and neutral tones because they show less dirt and are the easy way out in matching pieces and blending accessories. Give your rooms a lift with the loveliness of bright colors." This drabness may be the very thing the hospital designer finds in the woodwork and furniture of the rooms with which she is concerned. She need not be discouraged—she can make her rooms sing with color in fabrics and accessories.

Blessed are you when you come to do redecorating if the colors have been wisely chosen for first wall treatment. Should you have to make radical changes in color of paint, a scratch or marring of any kind will be the more pronounced. If you have to make use of a "handy man" for painting, be sure he understands the correct methods in repainting enameled surfaces. In your enthusiasm for colors, do not think you can turn a walnut-finished bed into a glamorous magazine-pictured blue with a few strokes of the brush—a cleaning-off job must be done first.

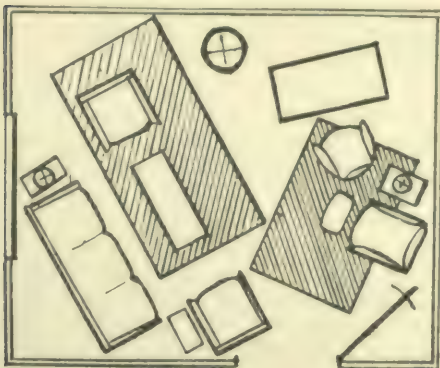
Psychologists declare colors possess definite personalities. Red is vibrant and attracts attention; yellow is cheerful and refreshing; blue is cool and restful. Chemotherapy makes use of these notions, placing hyperactive patients in blue rooms for a quieting influence; treating depressed patients in cheerful rooms of yellow, etc.

The professional decorator has many tricks for making things look other than they are. Can we make use of any of them?

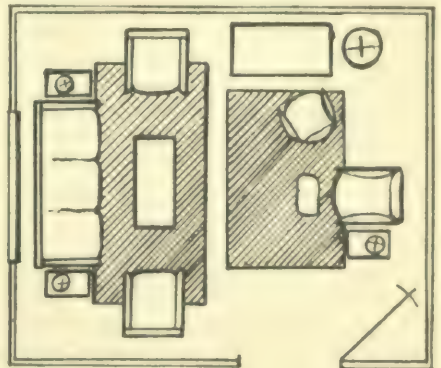
Patients' rooms are always small in comparison to the large pieces of furniture they must house so we gratefully utilize any means of giving a more spacious appearance. Keeping walls and woodwork the same light color is a surprising help. Mirrors help to make a small room seem larger, but the wise nurse will manage so that a very sick-looking patient does not get a chance to view himself (or herself). If the ceiling of room is low, a little of the wall colors should be mixed with the ceiling white to form a closer relationship between walls and ceiling and give a feeling of height. Vertically striped patterns in drapes will give height to windows. Patterns in drapes and upholstery should not be overly large. A landscape or seascape gives a sense of space. If a window is high and narrow, draperies may hang over the wall so that they just cover the wooden window-frame.

Pictures should be kept at eye height; in groups of pictures the bottom of the pictures should be in the same straight line. Framed mottoes or verses are not suitable in rooms for the sick. What a strain on the eyes as the patient tries to read them in spite of himself!

When scatter rugs are used in any room they should be placed in straight lines to achieve restfulness; for the same reason furniture



It looks cluttered!



Attractive and restful

should not be placed at an angle in the corner. Fussy lace or linen chair-back sets are not considered in good taste by professional decorators. These detract from the beauty of a room and say too bluntly, "You are likely to soil the back or arms of this chair." Incandescent lighting is recommended for restful atmosphere rather than fluorescent which is more suitable for centres of activity.

The nurse decorator will be able to express her personality when she plans her own rooms though in the hospital proper she has to think of the patient and the public. In schemes for living rooms more care should be taken to study colors under artificial as well as natural lighting. Thought must be given in placing furniture that correct balance is maintained. Cluttering of too many accessories is

a common fault. Why not use a few at a time and change them often? The nurse can fashion her bedroom so that its very vibrancy "makes her want to get up in the morning." Thus the color experts tell us (believe it or not!).

Four-year-old Marjorie Ann called excitedly from the kitchen to her mother in an adjoining room, "Mother, Mother, come quick. The soup is getting bigger than the pot." Color, line, and balance is growing bigger than the dish we have. We shall pull it off now before it boils over but we hope that this unfinished soup will encourage institutional nurses to add to their knowledge of obstetrics, pediatrics, geriatrics, etc., a more intimate acquaintance with esthetics—the science of the beautiful.

Parkinson's Disease

Paralysis Agitans, also known as Parkinson's disease, shaking palsy, shaking paralysis, and trembling palsy, is characterized by stiffness and involuntary tremors of certain muscles in the extremities. It is a chronic disease occurring in later life in men or women, more frequently the former.

The exact cause is unknown. It may occur following acute infections or exposure. Shock, injury, and anxiety are credited as contributing causes. It is not considered hereditary. The palsy is due to the degeneration of motor nerve cells at the base of the brain.

Insomnia, irritability, cramp, and tremor in some of the muscles of the fingers are early signs. Later, the fingers are flexed at the metacarpal joints and work against the thumb in such a way as to rest against each other. Gradually the tremors spread to the arm and leg on the affected side. It is not unusual for the condition to be unilateral for years before it progresses to the other side. The face muscles are seldom involved in the tremors. An anxious expression may be present. Later this disappears and the face will be mask-like and expressionless.

Articulation is not affected until the condition is well advanced. Speech may be slow with a hurried end to some sentences.

The characteristic gait of these patients

as the disease advances is known as festination. There is an involuntary increase or hastening of pace until it would appear the patient might fall forward. Should he be stopped and pulled backward, he will continue to back up—retropulsion—giving the impression he will fall in that direction though his body is bent forward. The body tends to bend forward from the hips with the head protruding whenever the patient stands.

Usually, the patient can continue in his occupation for many years after the first symptoms occur. Then, voluntary movements become more feeble and restricted and any excitement or effort causes the tremors to increase. Complete paralysis occurs only in far advanced cases.

So far, treatment is limited to sedatives and tonics which assist in reducing the tremors. Passive movements of the limb may be provided. Fresh air and good food are essential. All mental strain should be avoided.

There lurks in every human heart a desire of distinction, which inclines every man first to hope, and then to believe, that nature has given him something peculiar to himself.

—SAMUEL JOHNSON

Public Health Nursing

Problems in the Establishment of a Health Unit

MARGARET MACLACHLAN, B.Sc.N.

Average reading time — 12 min. 6 sec.

THE ESTABLISHMENT of any new service is a challenge with its increased responsibility, creative opportunities, and the many problems, some seemingly insoluble, to be faced. The solution is, at times, clearly seen following an analysis of the situation, while at other times the answer is only arrived at, step by step, through the method of trial and error.

In the establishment of a health unit the many factors, from which the majority of problems arise, would appear to fall into three main groups. *Local factors within the area itself* make up the first group and these are associated with the size of the area concerned; the extent, distribution, and racial extraction of the population; the geographical and topographical characteristics; and the predominating industry or industries engaged in by the population. Problems in this group are individual and peculiar to each area and can be solved only with the local characteristics in mind. A health unit establishing a program in an area of 1,500 square miles with a population of 50,000 will face problems quite unlike those arising in an area of 100 square miles with an 80,000 population. Likewise a rural area in a northern section is confronted with difficulties concerning weather conditions and transportation which do not to the same extent affect a comparable area in a southern section of the country.

The second group comprises *factors*

Miss MacLachlan is director of public health nursing with Simcoe (Ont.) County Health Unit.

within the unit itself. Problems in this group are usually those of salary, conditions of work, arrangements regarding transportation, etc. With the development of so many official public health programs, policies covering these matters are gradually being established and standards set, with the result that those services which do not keep pace quickly lose personnel. Demand has a way of taking these problems, to an extent, out of local hands. Nevertheless, the senior personnel in any health unit must be ever aware of current trends and be able to convincingly present their needs to those who control the policies—and the money.

The third group of factors may be said to concern *matters which are more general in character, basic in need, and of similar nature regardless of the area served or the type of population encountered.* Therefore, a solution that is effective in one locality has more likelihood of success in another. Problems encountered in this group arise from matters such as—the awareness, by the population concerned, of the service to be established; the insufficient amount of time available to the senior personnel for assessment of the area and the development of basic policies before the program itself begins; the inability to make provision in the budget for capital expenditures, and so on.

The majority of health units at present in operation have faced that overwhelming problem of public unpreparedness for the service they are endeavoring to establish. Is it inevitable that much time and effort

during the first year or so be spent informing people, individually and collectively, who we are, why we are here, and what we are trying to do—in short—in defending our existence? Are we accepting this as an unavoidable part of that period of organization, or should more thought be given to public awareness of the need for the service, and of the method by which this need may be met, especially in those areas where health units are contemplated? There is no thought here that continuous, informative public education is not part and parcel of every public service. Especially is this true of official agencies since taxpayers have every right to know how their money is being spent. Neglect in sufficiently publicizing a service often results in failure to stimulate interest and so falls short of eliciting the necessary support of the program offered.

Simcoe County is extremely fortunate in that, for the past ten years or so, the rural areas have been offered a program of adult education. Its basic philosophy has been the theory that action in any community stems out of an awareness by its people of particular needs or problems; that this awareness can lead to a study of the means by which these problems may be met and that a plan of action can be developed—i.e., "a program of study and action." Thus, a few years ago, many communities within the county instituted a study of their health needs. They learned what other provinces and counties had in the way of health services—both curative and preventive. They began to realize their own lack of an overall, organized public health program and, most important of all, they began to be vocal about what they wanted done about it. Results came slowly but inevitably. Perhaps the first concrete evidence of action was the establishment by rural school boards of "free" dental services, of "free" vitamin therapy, etc. We still have a job to do in educating people that nothing is really free—somebody has to foot the bill!

When, in 1944, the School Health

Service was established in the rural elementary schools, the personnel found community groups—Farm Radio Forums, Federation of Agriculture, and Women's Institute branches—prepared to give intelligent consideration to the program that was being developed. However, it was soon realized by some that the various types of public health services operating in the urban and rural areas were unco-ordinated and insufficient and, therefore, not meeting their needs. Again these groups provided the starting-point from which came the demand for a more comprehensive and co-ordinated public health program. Since the establishment of the health unit on July 1, 1948, members of the health unit personnel, on request, have brought to the people in the communities factual, up-to-date information regarding either the overall picture or some aspect of the work. It is our belief that an informed public creates a more intelligent opinion and thus tends to be more co-operative. We hope, as time goes on, not only to keep the people—the taxpayers—up to date on our work, its aims, accomplishment, and its failures, but also to bring to these groups information along specific lines—mental health, infant and child care, communicable disease, sanitation, etc. Another angle of this method of public education is that we find these groups more willing to let us know what *they* think of the service given, and of needs which are not being met. Thus we hope to offer a more efficient program and one geared to the need as experienced in the communities.

In spite of the preparation made in this field of public education for the establishment of the health unit we have found that the job was by no means complete. Many people, especially at the local level, had little idea of what was taking place. Though aware of the fact that a new program of public health education and supervision was being brought in they appeared to have little idea of what was involved. The history of health unit development has shown that it is

necessary to bring the information to the people directly, as well as through the press. Thus it would seem advantageous that some provision be made whereby this knowledge might be passed on to these people before the actual program gets underway so that they may be in a position to co-operate intelligently and freely.

One suggestion might be that the senior personnel—the medical director and officers of health, the director of nursing and nursing supervisor, and senior sanitarian—be engaged and at work for a period of time prior to the coming of the rest of the staff. The length of this period would vary according to the size and situation of the area to be served. We feel, in this health unit, that three months would not have been too long. If this had been possible, not only would there have been opportunity to explain the proposed set-up to interested individuals and groups—for which time had to be taken later when the demands were already heavy—but as well this period would have offered an opportunity to assess the area, its needs, assets, and potentialities. We are convinced of the merit of such a period of “pure” preparation since considerable benefit was derived from the medical director being able to come to the area one month prior to the date of establishment. The director of nursing services, who, since 1944, had been with the County School Health Service, was able, for a considerable period of time, to turn her energies to organizational work. The staff nurses came on duty one month after the date of the establishment of the unit. During that time basic policies were discussed and developed by the senior personnel and a plan for action arrived at.

From the point of view of the nursing staff it was decidedly advantageous that this time was available for preparation of the orientation period when the staff nurses arrived. At this time the policies formulated by the senior personnel were discussed and accepted by the nursing staff as a whole. Representatives from the various agencies operating within the

county explained their work to the group. Nursing policies and techniques as applicable to a generalized program, and to our unit, were reviewed. Most important of all, perhaps, the staff became acquainted with one another and conscious of themselves as part of the health unit team. Much of the value of an orientation period is lost if it is not held at the opportune time. It is, of course, impossible to attempt one if the time for preparation is not available. A well-planned and well-timed orientation period sends the new staff members to their districts with an increased feeling of security.

It is true that the strength and rate of development of any new service depends, to a large extent, upon the foundations. It would almost seem better to wait for increased pressure, due to increased knowledge, from those for whom the service is devised, than to start the service and later spend considerable time selling the idea. That these foundations must be strong might be one condition governing the establishment of a health unit, or any public service for that matter.

Since it has never been the practice in establishing health units to include in the initial budget sufficient money for capital expenditures many problems are likely to arise. Boards of health are faced with the necessity of having to cut down on the number of personnel engaged so that those employed may be provided with the necessary equipment and a place or office from which to work. This results in the program being launched on a smaller scale than was anticipated by the public, which often brings down on the heads of the professional personnel a considerable amount of criticism. Since official programs are tax-supported it is not possible, to the same extent, to concentrate the work in one area so that a demonstration of an adequate program may be given and in this way influence a budget increase to ensure more personnel as soon as possible. Frustration is experienced by staff and public alike. Patience and

wisdom are required to face these problems and still visualize what an adequate public health program can mean. New health units would get off to a smoother start if capital expenditures could be included in the initial budget.

Realization on the part of the health unit personnel, that the public health program is but one aspect of the total plan influencing the community, ensures a greater degree of integration of the various public services and closer co-operation between the personnel employed in those agencies. The professional personnel working on a county basis is, in Simcoe County, endeavoring to gain a wider knowledge and a greater understanding of the community and the influences bearing upon it. This entails knowing as much as possible about the services of the various agencies involved—the social agencies; the library facilities; the public health program; the agricultural program; the educational programs, both formal and adult; the recreational program, etc. We are finding, through experience, that this organized study of the community, its needs and

potentialities, is resulting in greater co-operation between the agencies and is leading to the development of a more integrated plan of action that is concerned with the community as a whole. Through this means many problems, which might arise through misunderstanding, a feeling of competition, or lack of knowledge of the aims and policies of other services, are being avoided.

This is but a brief discussion of a few of the challenging problems that accompany the organization of health units. It is important that in finding the answers to these difficulties we keep in mind the first purpose of a public health program, which is the enhancement of the health of the family. The health of any one family member is adequately dealt with only as we consider him in relation to the total family picture. Community health is the sum total of the health of the families living therein. Thus the program of a health unit is a challenge to each member of the staff and success can be achieved only when the total personnel work as a co-operative, co-ordinating team.

Nasal Hemorrhage

It may not be generally known that 95 out of a 100 nasal hemorrhages originate in the same area, which lies in the anterior cartilaginous portion of the nasal septum.

Why does bleeding occur in this place? There are two explanations for it. First, the occurrence of distended veins within the anterior portion of the cartilaginous nasal septum. The veins are so superficial and show such a vulnerability because of their thin walls, that relatively slight happenings, such as coughing, sneezing, blowing the nose, or bending the head, are sufficient to cause a bursting of a part of the dilated vessels. Once injured, these vessels cannot retract.

The second cause is a traumatic factor. The anterior portion of the nasal septum is, more than all other sections of the nasal cavity, exposed to traumatic insults, especially to the picking finger-nail. It injures

the superficial veins and causes a hemorrhage. Blood clots in this part of the septum are frequent. The mucous membrane remains congested; secretion dries and sticks in this place. This condition tempts the owner to remove the dry secretion with the finger and produces new hemorrhages. It is a vicious circle.

The simplest therapy is to compress the bleeding area by inserting a hard pack of cotton into *each* nostril and pressing them against this anterior portion of the septum, by squeezing the nostrils together from outside with two fingers. The pack should be left on the bleeding side for 24 hours. In both types, after the bleeding has stopped temporarily, cauterization of the vessel has to follow in order to definitely cover the gap in the vessel's wall.

—*Rocky Mountain Medical Journal*

Private Duty Nursing

Lichen Planus

GERALDINE O'KANE and AGNES MCCAWELL

Average reading time — 7 min. 12 sec.

LICHEN PLANUS is an inflammatory disease of the skin and mucous membranes, the cause of which is unknown. It is characterized by a very itchy eruption of flat polygonal red or bluish-red papules that vary in size from a pinhead to that of a small pea. The centres of the papules may be depressed or resemble warts. These may be scaly or covered with a network of glistening white stria. The papules are usually arranged in patches separated by the natural lines of the skin, which they exaggerate. This eruption may appear on the buccal mucosa before the skin is involved.

The treatment of lichen planus includes tar baths and ointments, bismuth intramuscularly, arsenic by mouth or intravenous injection, and careful use of x-ray irradiation if necessary. Ointments containing phenol, menthol, ammoniated mercury, and zinc oxide may be used to relieve the itch and barbiturate sedation aids in keeping the patient comfortable. Although it is a protracted disease it eventually clears completely with or without treatment.

CASE HISTORY

On August 7, an extremely itchy red area appeared on the inner aspect of Miss Fry's feet. On August 14, she noticed a hard yellow layer forming on the surface and soles of her feet. This area was very itchy and became increasingly sore. Her ankles commenced to swell and small reddish-blue spots appeared scattered sparsely over her arms and legs, necessitating partial bed rest.

Miss O'Kane and Miss McCawell are instructors at the school of nursing, St. Joseph's Hospital, Hamilton, Ont.

On August 25, her condition resembled that of a rheumatic patient, as the feet were thickly calloused, sore and itchy. These excrescences were incised and a culture taken of the watery exudate. This was found to be staphylococci in origin. The rash on her arms and legs was becoming more irritating. There was an elevation of temperature to 100°. Throughout the course of the disease her temperature ranged 99°-100°.

On September 6, Miss Fry was admitted to hospital and a new course of treatment was begun. This included complete bed rest and ultraviolet therapy daily to the point of producing erythema of her legs and back. Boracic solution compresses were applied to her feet every four hours for two days. September 8-15 her feet were kept wet with Dakin's solution continuously. Saratoga ointment was applied to the soles of her feet twice daily.

Medication consisted of sodium salicylate gr. V, t.i.d. and h.s. until September 14. On September 16 the dosage was increased to gr. XV, using the enteric coated sodium salicylate pills. These were continued until September 25 as there was still doubt as to the diagnosis. Salicylates are used specifically in treating rheumatic fever because of their analgesic and antipyretic action. Large doses are given because effect occurs only when the saturation point has been reached. Tablets containing codeine gr. $\frac{1}{4}$ were given t.i.d. and h.s. to relieve the intense itching. Nembutal gr. $1\frac{1}{2}$ was administered at bedtime to relieve restlessness and sleeplessness. For four days it was found necessary to give this dosage of nembutal at 2:00 p.m. also. During this time liquor arsenicalis min. I was begun three times a day after meals. The dosage was increased by one minim daily until min. IV was being given three times a

day after meals. Then it was reduced at the same rate and was discontinued September 25.

Chronic skin diseases are frequently treated with arsenic preparations because of its effect on metabolism. It aids nutrition and growth and sometimes stimulates formation of blood.

On September 10, Sherman's (rheumatoid) mixed vaccine (No. 7) was administered subcutaneously beginning with min. III, increased by min. II every three days until min. XVI was reached. Then min. XVI were given every week.

Vitamin K, one tablet daily, was given from admission to maintain normal prothrombin time. Vitamin C 100 mg. was administered twice daily until September 14. This medication prevents the gums from becoming sore and bleeding. The dose must be repeated often because it is not stored in the tissues. After September 14, combined vitamins in capsule form were administered three times a day, one-half to one hour after meals. These are used in anorexia, anemia, undernourishment, and infection which may be due to a deficiency of vitamin C, especially when intake of the food is contraindicated. A special mouthwash was used three times a day before meals and at bedtime. This mouthwash was soothing and antiseptic in action. Three times a day a general body rub with a soothing ointment was given. When necessary, Benadryl capsules, two three times a day, were given for comfort.

A series of weekly injections of bismuth salicylate in oil ($1\frac{1}{2}$ cc. into the buttock muscle) was started during Miss Fry's stay in the hospital. These were discontinued after the fourth injection when a dark bluish line was noticed on her gums. This is a symptom of toxicity in those receiving bismuth.

On September 24 and October 1, x-ray treatments were applied to the anterior surface of her arms and the flexor surfaces of her legs.

Between her admission date and September 25 the purplish rash had spread to

cover Miss Fry's entire body which became sore and itchy. Her mouth and throat were covered with a thick white coat which interfered greatly with eating. Her finger-nails and toe-nails became yellow, thick, and loose.

Miss Fry was given a diet rich in green vegetables. Until September 24 the fats and sweets were limited. It was quite difficult for her to masticate food due to the sores in her mouth and throat, with resultant loss of sense of taste.

The patient, always a moderate smoker, began to smoke almost continuously. Every effort was made to have this practice stopped but with the continued periods of restlessness and sleeplessness this proved quite a task for the nurse in charge. However, with the co-operation of her friends we did succeed in reducing the number to about four or five a day.

During the entire illness, periods of mental depression were common. Reading held her interest for a time but it was noted that she would frequently change to another article before completing the one commenced.

On October 5, Miss Fry was discharged from hospital. She remained an out-patient, receiving plenty of rest, in her own home for some time. Her body still displayed a rash and her appetite was poor. During November she lost considerable weight and became very listless. Gradually, during the latter part of November, the rash faded, leaving a densely mottled skin surface. The itchiness disappeared and her feet healed, although they remained very tender to touch. Miss Fry's mental attitude improved. She became more cheerful and interested in her surroundings and expressed a desire to return to work. She was still quite embarrassed with the color of her skin. Fortunately none of the blotches appeared on her face. She was able to resume her normal activities, with scarcely a trace of her rather rare condition.

Depression is thought to be commonly associated with the menopause. With normal women depressive moods do not reach pathologic proportions. If a woman undergoing menopause is unduly depressed she is

either of a cyclothymic personality and has experienced depressive moods before or is a psychoneurotic of long standing, or is undergoing a reactive depression with circumstances having nothing to do with menopause.

Aux Infirmières Canadiennes-Françaises

Semaine de Santé à Lévis

CÉCILE DEMERS

Lecture — 8 min. 48 sec.

AU MOIS de juin dernier avait lieu à Lévis la Semaine de Santé, organisée en collaboration avec la Chambre de Commerce des Jeunes de Lévis et le Ministère de la Santé.

Cette Semaine de Santé n'était qu'une intensification du programme continu d'éducation en hygiène, qui se poursuit depuis plus de deux ans dans le comté de Lévis. Après avoir jeté l'idée de l'organisation d'une Semaine de Santé à un organisme intéressé à l'avancement de l'hygiène publique, telle que la Chambre de Commerce, il était facile d'obtenir toute la collaboration possible.

Mlle Demers est éducatrice-hygiéniste avec l'Unité Sanitaire de Lévis, Qué.

L'objectif de cette Semaine de Santé était de rendre notre population plus consciente de nos problèmes d'hygiène et de l'importance de l'hygiène dans la vie de chaque individu, afin de prolonger sa vie, conserver sa santé, et éloigner la maladie.

On ne peut faire l'éducation de quelqu'un malgré lui. Pour préparer le terrain à l'éducation populaire il est essentiel d'avoir la participation du public, ou le public ne se mettra à l'oeuvre que si l'on a d'abord éveillé son intérêt. Le programme d'éducation en hygiène mis en action, après avoir étudié la situation sanitaire du comté par nos statistiques de la mortalité et morbidité, nous avons constaté qu'il était urgent d'attaquer les problèmes les plus imminents: la



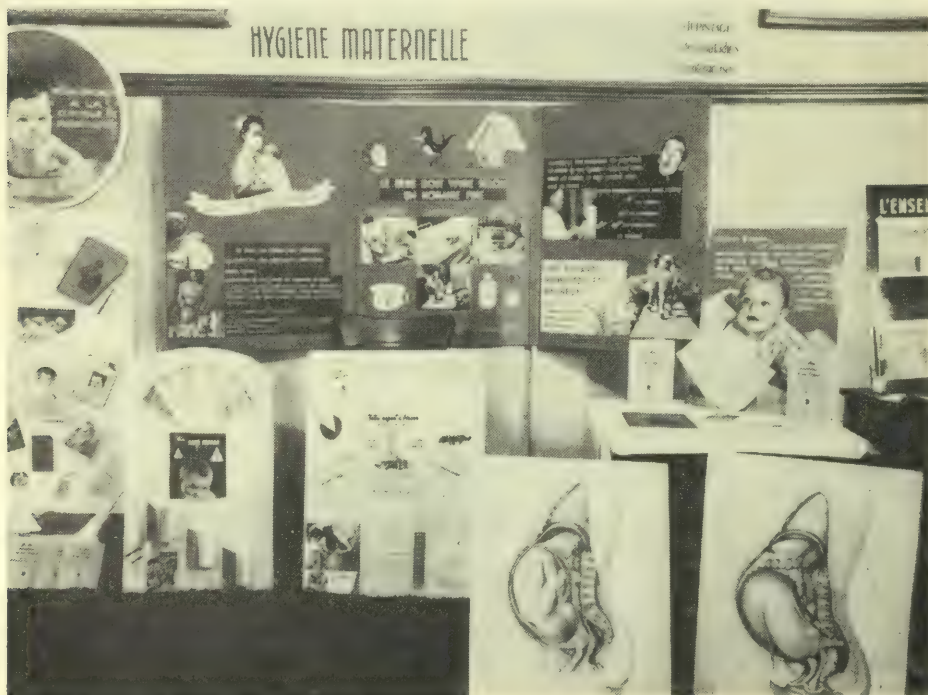
tuberculose, le cancer, l'hygiène maternelle et infantile, et les maladies vénériennes. Nos organisations sociales, intéressées au programme de l'éducation en hygiène, étudient ces divers problèmes de santé et, toujours avec leur collaboration, nous travaillons à résoudre ces problèmes.

Avec la Semaine de Santé, on a constaté chez tous beaucoup d'intérêt envers nos problèmes d'hygiène. Les problèmes furent exposés d'une manière aussi concrète que possible; les moyens d'enseignement visuels furent à tour de rôle employés. Le programme comportait des conférences avec films, des exhibits, et des démonstrations pratiques sur les problèmes de santé les plus urgents, tels que la tuberculose, le cancer, l'hygiène maternelle et infantile, l'hygiène alimentaire, et l'hygiène dentaire. Une bonne publicité avait préparé les voies à cette Semaine de Santé—des articles aux journaux et des causeries à la radio avaient mis l'attention du public en éveil pour profiter de cette semaine.

Chaque jour de la semaine avait au programme un sujet différent à l'étude. Après avoir assisté à une représentation de films sur un pro-

blème de santé quelconque, l'assistance pouvait visiter l'exhibit sur le même sujet et s'enrichir de plus de connaissances. Des infirmières se tenaient aux kiosques pour donner des explications et répondre aux questions des personnes avides de se renseigner. De la littérature était aussi distribuée aux personnes qui en faisaient la demande. Un exemplaire de chaque publication distribuée par le Ministère de la Santé et par la Compagnie Métropolitaine était exposé en évidence, afin que le public se renseigne davantage sur nos meilleures sources de documentation et continue ainsi de s'intéresser aux problèmes multiples de santé publique et individuelle. Combien n'ont-ils pas trouvé des moyens d'améliorer leur santé ou de résoudre leur problème de santé, en prenant connaissance de cette littérature? Il faut que toute publication soit distribuée à bon escient et à des personnes intéressées afin d'atteindre le but désiré.

Ce qui a le plus retenu l'attention du public fut l'exposition de la santé. Cette exposition était composée de différents kiosques sur divers problèmes de santé. Le but de cette exposition était de renseigner d'une





manière plus concrète, de faire réfléchir ou agir. Le public en général fut très intéressé à visiter les kiosques de la tuberculose et du cancer, tandis que l'hygiène maternelle attira une foule nombreuse de mamans et même de messieurs. Les questions posées furent nombreuses et très pratiques surtout de la part des personnes qui avaient assisté aux représentations de films sur l'hygiène maternelle. Le livre, "La Mère canadienne et son Enfant," distribué sur demande au kiosque, eut grande vogue.

Les jeunes gens et les messieurs furent particulièrement intéressés à visiter le kiosque traitant des maladies vénériennes. Là aussi des questions nombreuses furent posées et une demande considérable de littérature démontra l'intérêt manifesté pour se renseigner davantage sur un problème de santé aussi important. Les élèves de nos diverses institutions, accompagnés de leurs professeurs, étaient invités à visiter l'exposition de la santé. Des explications, sur chaque kiosque, leur furent données. L'intérêt des élèves et des professeurs était vraiment marqué. Il était très intéressant de répondre aux questions aussi variées que pratiques des différents groupes de visiteurs.

Avec cet exhibit nous avons obtenu une large part de notre objectif qui

était de renseigner, de faire réfléchir ou agir. Après cette Semaine de Santé nous avons constaté une plus grande assistance aux cliniques anti-tuberculeuses et anti-vénériennes; nombre de jeunes gens se sont prévalus de l'examen du sang B.W., après en avoir compris les avantages.

Là ne s'arrête pas le travail de l'éducation en hygiène. Beaucoup a été obtenu du public de notre comté, depuis l'organisation du programme de l'enseignement en hygiène, mais il reste encore beaucoup à accomplir. Tant que le cancer et la tuberculose continueront à faire leurs ravages parmi notre population, tant que les maladies vénériennes se multiplieront, et que les taux de mortalité et de morbidité maternelle et infantile n'auront pas atteint le minimum, il reste encore beaucoup à réaliser. Le travail d'éducation est un travail de longue haleine et les résultats sont parfois lents, mais en autant que la collaboration du public nous est accordée, il y a lieu d'espérer des résultats durables.

Espérons qu'avec cette Semaine de Santé notre population a compris une fois de plus que toutes les semaines de l'année devraient être une Semaine de Santé. Nous pourrions compter ainsi, dans un avenir rapproché, une population plus saine et plus forte.

Nursing Profiles

In every province in Canada the scores of friends and admirers of **E. Kathleen Russell** are delighted to learn of the latest honor that has been bestowed upon her. Long an ardent advocate of international understanding among nurses and very active in promoting this cordial relationship through the University of Toronto School of Nursing where she is the director, Miss Russell richly deserves the award of the Florence Nightingale Medal.

This Medal, which was instituted in 1912, is conferred biennially by the International Committee of the Red Cross Society upon nurses who have rendered conspicuous service in war or disaster, or who have made other notable contributions to the public good. Miss Russell is the sixth Canadian nurse to be given this decoration.

Born in Windsor, N.S., of Irish and Canadian parentage, Miss Russell secured her B.A. from the University of King's College in Nova Scotia before she entered the school for nurses of the Toronto General Hospital in 1915. When she graduated she was recipient of a scholarship which enabled her to study in the Department of Social Service at the University of Toronto. She also

holds her B. Paed. from that university. At the sesquicentennial celebration of King's College in 1939, her *alma mater* conferred upon her the degree of D.C.L. (*honoris causa*) in recognition of her attainments in the field of nursing education.

After one year of supervisory experience with the Department of Public Health in Toronto, Miss Russell was appointed in 1920 as director of the newly established Department of Public Health Nursing at the University of Toronto. Seven years later, a new pattern of nursing education began to emerge with the development of the so-called "four-year course." Through her dynamic drive and clarity of vision, the present school of nursing came into being in 1933 assisted to a considerable degree by the Rockefeller Foundation.

Miss Russell's interest in nursing education has not been confined to one school. She was one of the first to advocate the making of a survey of nursing education in Canada and served as a member of the Joint Committee which guided the project some twenty years ago. Special recognition of her many contributions to nursing education in Canada was made in 1940 when Miss Russell was awarded the Mary Agnes Snively Medal by the Canadian Nurses' Association.

In 1942, the Canadian Red Cross Society appointed Miss Russell as their nursing consultant. No better choice could have been made of an interpreter of the aims and ideals of nursing to this very active lay group which carries on so many valuable enterprises for the betterment of the health of Canadians. It was because of Miss Russell's interest and salesmanship that the generous grant was made by the Canadian Red Cross Society for the development of the demonstration school of nursing in Windsor, Ont.

The nurses of Canada are proud of Miss Russell and rejoice that international recognition of such a high order has been conferred upon her.

Eleanor Scott Graham has been appointed the director of nursing and principal of the school of nursing at the Royal Columbian Hospital, New Westminster, B.C. A graduate of the Vancouver General Hospital, Miss Graham holds her B.A.Sc. degree from



Ashley & Crippen

E. KATHLEEN RUSSELL

the University of British Columbia and her Master of Science from the University of Chicago. She had engaged in public health nursing activities in several centres in British Columbia before she was appointed second assistant superintendent of the Victorian Order of Nurses for Canada. More recently she was health instructor at the Metropolitan School of Nursing, Windsor, Ont. Miss Graham has been active in nursing association work in both British Columbia and Ontario.



Sherick, Toronto

ELEANOR S. GRAHAM

Blanche Gertrude Herman, R.R.C., has resumed her duties as supervisor of nurses at the Western Division of the Montreal General Hospital which she had carried on so successfully from 1933 until her enlistment in the R.C.A.M.C. in 1941. Born in Lunenburg, N.S., Miss Herman graduated from the Montreal General Hospital in 1925. After a brief period in private duty nursing, she became head nurse on a private ward. She received her certificate in administration from the McGill School for Graduate Nurses in 1930 and went to the Royal Victoria Montreal Maternity Hospital for two years as assistant supervisor.

Miss Herman had a brilliant record of service during World War II. She went overseas as matron of No. 14 C.G.H., and accompanied this unit to Italy in 1943. That year she received the well-earned honor of the Royal Red Cross, first class. She was appointed senior principal matron for the



Adolphe, Montreal

BLANCHE G. HERMAN

R.C.A.M.C. in Italy and received mention in despatches for her devotion to duty.

Mildred Brogan, staff nurse with the Bell Telephone Company since December, 1947, has been named to the newly-created position of nursing supervisor for that company in the Montreal area. Among her tasks will be the direction of Bell nurses in their professional duties, including training, assigning work, and making certain that established medical procedures are carried out efficiently and correctly. She will supervise health education programs conducted by the nursing staff. Miss Brogan will also conduct research covering all phases of nursing and training procedures within the



Millar Studio, Montreal

MILDRED BROGAN



Rice, Montreal

BERTHA BIRCH

company and will act as liaison officer for the Bell nursing group in establishing contacts with other nursing groups in industry and teaching work.

Miss Brogan received her bachelor of arts degree from University of Montreal in 1939, graduating from the Montreal General Hospital School for Nurses in 1942. She took a course in teaching and supervision at the McGill School for Graduate Nurses in 1944 and returned to the teaching staff at M.G.H. until she entered industrial nursing.

In February, 1949, she was awarded a scholarship through the McGill School for Graduate Nurses to take a special course in industrial nursing at the University of Pittsburgh.

H. Berniece Lewis has taken over her new duties as director of nursing at the Public General Hospital, Chatham, Ont. Following her graduation from that hospital in 1939, Miss Lewis enrolled for post-grad-

uate work at the University of Western Ontario. She accepted a position as assistant superintendent of nurses at Port Arthur General Hospital and later was superintendent of nurses at the Norfolk General Hospital in Simcoe. For the past three years she has been associated with the Public General Hospital, in the capacity of night supervisor for two years and latterly as obstetrical supervisor.

Last October, **Bertha Birch** severed her long connection with the Western Division of the Montreal General Hospital where she has been supervisor of nurses since 1941. Miss Birch's association with this hospital goes back for 40 years to the days when she arrived in Montreal from Chatham, Ont., her early home, to begin her training at the Western Hospital. All of her professional life has been spent here. For 19 years following graduation, Miss Birch was supervisor of the operating-room and assistant superintendent. When the Montreal General Hospital took over the premises as a private ward unit, Miss Birch became the night supervisor.

Her serene manner, keen sense of humor, and sincere appreciation of people's worth have endeared Miss Birch to all with whom she worked. She plans to reside in Montreal.

Anna Maloney has retired from her post as supervisor of the St. Elizabeth Visiting Nurses' Association in Hamilton, Ont., after 28 years of faithful service. She had been with the association since its inception and was devoted to the task of looking after the sick in their homes to whom she gave unstintingly of her time and skill. A beautifully illuminated address was presented to Miss Maloney in which was expressed the deep affection all her co-workers and patients felt for her.

Although the color of light usually has little or no effect upon clearness and quickness of seeing, it may have important psychological effects. Color nearest to daylight is considered desirable by many authorities. In the discrimination of colors such spectral quality is essential. Tungsten filament light is relatively deficient in green, blue, and violet radiations as compared with daylight.

While this makes it unsuitable for color judgments it is satisfactory for ordinary purposes. Visual acuity (the ability to distinguish fine detail) is good under this light and the preponderance of yellow radiations makes it pleasing to most people. Some persons, however, are able to work longer with less fatigue under artificial light.

—Selected

Trends in Nursing

Average reading time — 5 min. 36 sec.

WHO Fights Tuberculosis

ON JULY 30, 1949, the Expert Committee on Tuberculosis of the World Health Organization concluded a five-day session in Copenhagen during which it drew up a series of measures designed to strengthen health administrations in underdeveloped countries in the fight against tuberculosis. These measures, together with other recommendations, will be submitted to the 18-member WHO Executive Board, scheduled to meet in Geneva in January. They will then be fitted into overall plans that are being carried out by WHO to combat tuberculosis, which is still taking life from five million people every year.

Any comprehensive tuberculosis control scheme in countries with underdeveloped programs, the experts agreed, should start with a survey of the needs, resources, and attitudes of the people. Once this preliminary work is done, a central group directed by a leader could go on with tuberculosis control activities, devoting much of its time to the training of personnel to become members of field teams throughout the country as the program develops.

The importance of training public health personnel in underdeveloped areas to ensure nursing services to patients and to staff laboratories as well as dispensaries and hospitals, necessary for the isolation and treatment of infectious cases, was stressed repeatedly by the experts. They pointed out that WHO could be of great assistance in setting up centres to train local personnel in all phases of tuberculosis control work and to serve as demonstration centres for medical and auxiliary personnel of the area. The Committee further suggested that WHO might give useful information on certain types of hospitals which could be set up in

a relatively rapid and economical way.

Health education was recognized by the Committee as an essential tool in tuberculosis control. It was urged that WHO should encourage national and international voluntary organizations to inform the public on all aspects of the tuberculosis program carried out in a particular country with the purpose of securing active support for it.

The value of tuberculin-testing and of BCG vaccination, as the only practical way known so far of producing specific resistance against tuberculosis, was reaffirmed by the Committee. Further, it was emphasized that BCG immunization could be fully effective only if used as a part of a general program in addition to the application of other available preventive measures. Mass vaccination with BCG was specially recommended for countries with high tuberculosis infection and mortality rates. However, it was pointed out at the same time that in all countries vaccination should be applied to individuals and groups for whom exposure to tuberculosis is likely.

In connection with BCG program the Committee heard a report on the work and plans of the research office which has been set up by WHO in Copenhagen to evaluate the results of tuberculin-testing and BCG vaccination now being carried out in the International Tuberculosis Campaign of the United Nations International Children's Emergency Fund, the Scandinavian Red Cross, and WHO. The experts agreed that results will be of great value to future planning of anti-tuberculosis campaigns on a world-wide basis.

Since the International Union Against Tuberculosis is expected to discuss the question of streptomycin at its next meeting in Copenhagen in 1950, the experts did not examine

this problem in detail. However, they did urge caution in the use of streptomycin, chiefly on the grounds that the drug is dangerous and that questions as to the type of patients who may benefit from it have not been fully answered yet.

The Committee warmly welcomed close co-operation with the League of Red Cross Societies and the International Union Against Tuberculosis. With regard to the latter, the Committee recommended that WHO, through its field staff, should encourage the development of voluntary anti-tuberculosis associations in countries where such societies do not yet exist and should promote their affiliation with the Union.

The Expert Committee on Tuberculosis is only one of the international groups which are to map details on plans adopted by the World Health Assembly a month ago in Rome for implementation in 1950 against numerous diseases and for better health throughout the world. The meeting in Copenhagen will be followed in the months to come by gatherings of experts on malaria, venereal diseases, maternal and child health, mental health, etc.—*Pan-American Sanitary Bureau Press Release*, Aug. 19, 1949.

Britain's National Health Service

The Minister has decided, on the advice of his medical advisers, to introduce the use of BCG vaccine on a limited and controlled scale, feeling that this form of immunization warrants trial.

It is proposed to offer BCG inoculations to all hospital nursing staffs. The general plan, agreed upon with the nursing organizations, will be to place information about BCG before the nurses and invite them in the light of this knowledge to make a decision whether or not they will be vaccinated.

The Ministry has prepared an explanatory leaflet for individual distribution and a full medical memorandum on the system in operation in Scandinavia will be made available. The responsibility for BCG vaccina-

tion, according to advice to the Minister, should rest on physicians with special knowledge and experience of tuberculosis or those especially chosen by chest physicians and trained in the technique of giving vaccine and recording results. The BCG, which is being imported by air from Copenhagen, will be provided free by the Ministry.

Records will be kept of nurses vaccinated and a study made over a considerable period of time to determine results.

BCG will also be available to chest physicians and other appropriate specialists who may wish to use it on their own medical responsibility. It will also be offered to medical students on the same general plan as outlined for hospital nurses.—THE MINISTRY OF HEALTH, Whitehall, S.W.1., Aug. 17, 1949.

Pioneering in Mental Health

Among all the groups who met in Geneva last summer the least noticed and perhaps the most important was the World Federation for Mental Health—the inter-professional body created in 1948 in London.

This inter-professional body was created for the express purpose of assisting the World Health Organization in fulfilling its functions with regard to mental health. Psychiatrists, psychoanalysts, social workers, anthropologists, penologists, nurses, clergymen, educators, and social scientists from 34 countries are represented in the Federation, membership in which is open to all professions interested in mental health.

What type of questions did the Federation discuss?

1. (a) The need for professional education and training in mental health work. (b) The need for public education in this field.
2. The mental health aspects of education with particular application to education in Germany.
3. The psychological aspects of religion and of international relations.

The theme chosen for research and investigation during the coming year

is "A study of the forces and conditions which raise men and women to positions of national and international leadership." Thirty-four countries and 300 groups will participate in this intensive research. The plan is first to concentrate on leadership in small communities and then move on to the national and international stage.

Observers from the WHO attended the Federation's meeting and were thus able to bring first-hand reports back to the WHO Expert Committee on Mental Health, which was beginning its meetings as the Federation adjourned. It was decided by the Expert Committee that, in the absence of adequate treatment facilities,

the main effort should be directed toward preventive mental health work and technical training of medical personnel; that the World Health Organization should take the lead in developing in each region a centre for psychiatric studies. Such centres would teach the modern, dynamic conception of psychiatry to all members of the psychiatric team.

Such fields as alcoholism, drug addiction, crime prevention, etc., are included in the list of proposed activities. A first step only has been made in this pioneer effort but that first step is of great importance to the health of the world.—*World Health Organization, Newsletter*, Sept. 1949.

Orientation et Tendances en Nursing

L'ORGANISATION MONDIALE DE SANTÉ

La tuberculose fait encore cinq millions de victimes par année à travers le monde. Devant ce fait, l'O.M.S. a chargé un comité de spécialistes de déterminer les mesures à prendre et les recommandations à faire dans le but de combattre ce fléau. La tuberculose sévit avec plus de force dans les pays dont l'économie est moins développée. Le comité de spécialistes en tuberculose s'est réuni à Copenhague et a délibéré durant cinq jours. Le rapport sera soumis à l'O.M.S. lors de la réunion de janvier à Genève.

Voici quelques-unes des mesures et des recommandations du comité: Un programme de lutte contre la tuberculose dans un pays, où l'économie est moins développée, doit commencer par une enquête afin de connaître les besoins, les ressources, et les dispositions d'esprit de la population. Lorsque ce travail préliminaire est terminé un groupe initial, venant ordinairement d'un pays plus avancé, commence la lutte sous la conduite d'un directeur. Le gros du travail à ce stage est d'appuyer les services de santé existant déjà en formant un personnel entraîné parmi les habitants du pays. Lorsque la formation d'un groupe est terminée, chaque membre assume la direction d'une nouvelle équipe, qui reçoit, à son tour, une formation spéciale et va, à travers le pays, assurer le développement du programme à réaliser.

La formation du personnel dans ces pays peu avancés est d'une importance primordiale. Il faut bâtir une armature solide sur laquelle viendront s'appuyer tous les services de santé, dispensaires, hôpitaux, laboratoires, et tout le personnel requis pour isoler les contagieux et traiter les tuberculeux.

Une autre recommandation de ce comité de spécialistes est d'établir des centres de démonstrations dans divers régions du pays. L'on recommande que l'O.M.S. renseigne à ce sujet certains hôpitaux qui pourraient devenir à peu de frais des centres anti-tuberculeux.

Dans la lutte contre la tuberculose l'éducation du public est indispensable. Le comité recommande à cette fin d'inviter les organisations bénévoles, nationales et internationales, à renseigner le public sur tous les aspects de la lutte anti-tuberculeuse.

Le comité constate qu'à date le meilleur moyen pour combattre la tuberculose est la vaccination par le BCG. La vaccination par le BCG sur une grande échelle est recommandée dans les pays où le taux de l'infection et de la mortalité est élevé. Dans les pays moins éprouvés par la tuberculose, on doit également vacciner toutes les personnes exposées à contracter cette maladie.

L'O.M.S. doit évaluer les résultats obtenus par la vaccination BCG d'un grand nombre d'enfants, lesquels étaient sous la protection

de l'UNESCO. La Croix-Rouge et la Ligue Internationale Anti-Tuberculeuse prêteront leur concours.

LE SERVICE DE SANTÉ EN GRANDE-BRETAGNE

Dans ce pays le Ministère de la Santé offre à certains groupes la vaccination par le BCG. Cette décision du ministère fut prise sur la recommandation de conseillers au ministère.

L'on offre le BCG au personnel des hôpitaux, étudiantes infirmières, étudiants en médecin, et aux médecins spécialistes en tuberculose pulmonaire, qui pourront mettre le vaccin à la disposition de leur clientèle. On donnera des informations concernant le BCG et chacun restera libre d'accepter ou de refuser la vaccination. Des médecins spécialistes en tuberculose pulmonaire auront la responsabilité d'administrer le vaccin. Des dossiers de toutes les personnes vaccinées seront tenus et les cas revus à différents intervalles.

LA FÉDÉRATION MONDIALE D'HYGIÈNE MENTALE

Trente-quatre pays, membres de la fédération, assistaient à la réunion de l'été dernier. Tous les groupes professionnels intéressés en hygiène mentale étaient représentés.

Voici quelques-uns des points discutés lors de cette réunion: (1) Les besoins d'éducation et de formation professionnelle en hygiène mentale. Les besoins de renseigner le public en hygiène mentale. (2) Les différents aspects de l'hygiène mentale en éducation, avec l'application particulière à l'Allemagne. (3) Les aspects psychologiques des religions et des relations internationales.

Le travail de l'année portera sur l'étude des influences et des circonstances permettant aux hommes et aux femmes d'arriver à des postes, national et international, de commande.

Des spécialistes en hygiène mentale, envoyés par l'O.M.S. à titre d'observateurs à cette réunion, recommandèrent de diriger tous les efforts de l'organisation vers la prévention par l'hygiène mentale et vers la formation d'un personnel entraîné.

Il a été recommandé à l'O.M.S. de prendre le devant et de développer des centres d'étude en psychiatrie. Dans ces centres on enseignerait les conceptions modernes dynamiques de la psychiatrie à toute l'équipe psychiatrique, laquelle se compose de médecins, du psychologue, de l'infirmière, et de l'auxiliaire sociale

en psychiatrie, etc. L'étude de l'alcoolisme, de la morphinomanie, et de la criminalité est aussi au programme.

La fédération n'en est qu'à ses débuts, mais déjà ce travail aura une heureuse influence sur la santé du monde.

Milk Between Meals

"Milk requires 3 to 3½ hours for complete gastric digestion . . . To give it at 10:30 (in school) and then send the child home for lunch at 12 violates the rules of physiology, dietetics, and common sense. Experience shows that the appetite for lunch may be much impaired."

For nearly 5 months, 59 convalescent children in a rheumatic fever rest home were given a 7-ounce glass of milk twice daily, one hour before meals. These before-meal feedings failed to elicit in any child any undesirable symptoms of anorexia, gastrointestinal distress, or decreased consumption of food. The added milk proved a true dietary supplement, well taken and well metabolized.

No evidence was found in these experiments to warrant advising the discontinuance of drinking milk between meals. The data indicated, on the contrary, that it is wise to make available such extra servings whenever there is need for improving a child's nutritional status or food intake.

—*Journal of Pediatrics*

Temper Tantrums

Temper tantrums are emotional outbursts to gain a point through a method found to be effective in the past. The obvious answer to this would be for parents never to be influenced in changing a decision by such behavior. They should meet the behavior firmly, adhering to the decision, banishing the child to his own room, or administering a spanking then and there. The essential point is to rob the tantrum of its effectiveness and to make it unpleasant. Spanking is not condemned by psychiatrists. However, it should not be the first resort; it should be done privately, not a "beating"; it should not be the father's first duty on coming home and getting the mother's report; and not be done in anger. If children feel secure and loved and learn early to respect the parent's prohibitions, spankings will be necessary very rarely.



OUR PLAN UNFOLDS

1950! What does it mean to you? Does it mean Convention Year? Is **June 26** your Red Letter Day? If so, you must be wondering what the Program Committee has in store for you. I will let you in on the secret. The Canadian Nurses' Association is planning for a bigger and better convention than ever before—the meeting *you* cannot afford to miss. There will be something for everybody—the private duty nurse, the faculty member, the supervisor or teacher, the general duty nurse, the public health nurse, the industrial nurse, the administrator in hospital or community and, that very important person, the student nurse.

Another little secret—the program is *yours*, it will be what *you* make it. About 150 people—Canadian nurses—will be taking part officially, but—the program is so planned that every single nurse will find opportunity to contribute. Get together and think through your problems and, in the words of that old forgotten song—“Pack up your troubles in your old kit bag” and come to Vancouver. Even if you are flying you will have room for your problems—the air lines will never notice their weight, and who is going to tell them? Not you surely!

Last month we reported to you that we had secured consultants for the staff education conference. It is not too late to send in problems within the area prescribed by this or any work conference. National headquarters will be glad to forward such problems to the consultants and they in turn will be pleased to know where your interests lie.

LONG TERM PATIENTS

In view of the growing concern for the older patient and for those suffering from long crippling illnesses, you will be interested to learn that **Dr. Martin Cherkasky** of Montefiore Hospital, New York City, has consented to act as a consultant for the work conference, “Meeting the Total Needs of Long Term Patients.” This topic provides food for thought on the part of every nurse in whatever capacity she may be serving patients in her community.

EVALUATION AND ACCREDITATION

Another area of particular interest to special groups within the profession and to all who take a keen interest in nursing education is “Evaluation and Accreditation of Schools of Nursing.” Faculty members and nursing school advisers have a particular concern with the status of nursing school programs. Concern, however, is of value only if it stimulates action. Are you sufficiently interested in the changing pattern to consider the need for an evaluation program? If so, you are probably asking, “Where can I secure advice? What do I need to know? When can I make a start? How is an evaluation program conducted?” The Program Committee of the Canadian Nurses' Association proposes to help you answer some of these questions, through the instrumentality of the aforementioned work conference.

Such outstanding people as **Sister Denise Lefebvre**, director of the school of nursing, Institut Marguerite d'Youville, Montreal; **Agnes Macleod**, director of nursing, Treatment Services, Department of Veterans Affairs, and chairman of the Educa-

tional Policy Committee, Canadian Nurses' Association; **Margaret Street**, secretary-registrar, Association of Nurses of the Province of Quebec, and **Sister Mary Claire**, director of nursing, St. Joseph's Hospital, Victoria, are prepared to act as consultants and to assist you in every possible manner to solve your problems.

Come prepared to pool your knowledge and your problems—to take an active part in discussions and to help formulate policies for the future. Early registration in this and in every work conference assures you of securing the place where you most want to be and will greatly assist the Program Committee.

You already know that the University of British Columbia has opened its doors to the Canadian Nurses' Association. There will be plenty of room for meetings and comfortable quarters for members and all at extremely reasonable rates. The following will give you some idea of how much money you will need to put aside each month—from now until the middle of June, 1950:

Accommodation per person, per day, payable in advance—\$1.50.

Meals served on campus at very reasonable rates (tickets obtainable at registration desk).

See the October number of *The Canadian Nurse* for travel rates by air.

In Memoriam

Mabel Armstrong, who graduated from the Victoria Hospital, London, in 1923, died suddenly when preparing to go on duty on October 30, 1949. Miss Armstrong had engaged in private duty nursing for her entire professional career.

* * *

Mary Robena Fairweather, who secured her nursing training at Christ Church Hospital, Cincinnati, and who had given skilled care to the sick in and around Drayton, Ont., since 1910, died on October 16, 1949, in her 73rd year, after an illness lasting three years.

* * *

Mabel (Tangney) Kennedy, a graduate in 1912 of St. Michael's Hospital, Toronto, died on July 26, 1949, at the age of 60. Mrs. Kennedy had engaged in active nursing for five years prior to her marriage.

* * *

Teresa (Carey) Lee, a 1910 graduate of St. Michael's Hospital, Toronto, died on August 24, 1949, in her 64th year. Mrs. Lee served overseas during World War I.

* * *

Ethel (MacDonald) Linton, who was a graduate of the Calgary General Hospital in 1930, died in May, 1949. Mrs. Linton had been in poor health for about a year before her death. She was loved and respected by all the Calgary nurses.

Mary Mona (Ganderton) Mathewson, a graduate of the Edmonton General Hospital with the class of 1947, died suddenly in October, 1949, in Princeton, B.C., at the age of 25. Prior to her marriage four months before her death, Mrs. Mathewson was on the staff of the Princeton General Hospital.

* * *

Lucy Marie Parchem, who graduated in 1931 from Hotel Dieu Hospital, Windsor, Ont., died on August 3, 1949, in her 42nd year, following a long and exhausting illness. Miss Parchem spent most of her professional life as nursing director of the Webb Industrial Clinic in Detroit.

* * *

J. Ruth Reekie died in Toronto on October 25, 1949, following a prolonged illness. Miss Reekie was a former superintendent of nurses of the Guelph General Hospital and also of the Regina General Hospital. She had retired for some years because of ill health.

* * *

Dora Reid, who graduated from the Ottawa Civic Hospital in 1925, died at Gravenhurst, Ont., after an illness lasting many years.

* * *

Christina Sage, a graduate of Vernon Hospital, B.C., who had engaged in active

nursing in Lethbridge and Tranquille and who served overseas with the C.A.M.C. during World War I, died in Vancouver on October 30, 1949, at the age of 68.

* * *

Sister St. James, for many years the director of nurses' training at Hotel Dieu Hospital, Kingston, died suddenly while in

the midst of her teaching duties on October 3, 1949.

* * *

Veronica Winterhalt, a graduate of St. Michael's Hospital, Toronto, who had worked as a public health nurse in Kitchener, Ont., for 30 years, died on November 13, 1949. She had retired two years ago.

Memorial Library

Miss Natsuye Inouye, who is president of the Japanese Midwives, Public Health Nurses and Clinical Nurses Association, and is also a member of the House of Councillors of the National Diet, inspects a volume from the library presented to the nurses of Japan by the War Memorial Committee of the Canadian Nurses' Association. It is called the

Numo Memorial Library in honor of Miss Christine M. Numo, a public health nurse and teacher at St. Luke's General Hospital, now the Tokyo General Hospital, before the war. Miss Numo returned to the United States in 1941 and died there later. The books have been greatly appreciated by the Japanese nurses and are in constant use.



U.S. Army Photo

Banti's Disease

EVELYN WILMS

Average reading time — 15 min. 12 sec.

THE TELEPHONE rang one evening when I was on duty and the admitting officer informed me that a patient was on her way up to one of our semi-private rooms. She was suffering from Banti's disease. I vaguely recalled hearing about this disease and associated it with some type of hemorrhage, but before I had time to find out anything more the ambulance stretcher arrived with Miss Cox.

She was a middle-aged woman, 42 years old, and of medium build. Her short, dark, curly hair framed a very pale and apprehensive face. As we tucked her into a warm bed I did not notice any signs of the external bleeding that I had expected. She did not appear to be seriously ill, judging by the manner in which she responded to my questions, but I knew that she had recently been very sick because she was upset, nervous, and shaky, and had a marked craving for ice-cold water. The interne soon arrived and examined her. He found that her blood pressure was fairly low, 116/70, her temperature elevated to 99°, her pulse 104 per minute, very rapid and weak, but her respirations were normal. He stated that there were no signs of shock and decided, as he hurried off, that it was safe to leave the treatment, which was a blood transfusion, till morning. Morphine sulphate gr. $\frac{1}{4}$ was given hypodermically for epigastric discomfort and as a sedative to quieten her nerves. Later, I entered the room again to

see that Miss Cox was comfortable and warm and to check on her condition. I was disturbed to find that she had vomited approximately four ounces of clear fluid with intermingled strands of dark red blood. In an unconcerned manner she explained that she had vomited up about a basinful of dark red blood in the past two days. When she stated that these attacks had occurred periodically for over twenty years, it made me curious to find out what this Banti's disease was, and why they have not been able to stop these gastric hemorrhages.

DESCRIPTION

Banti's disease or syndrome, or splenic anemia, as it is often called, is regarded as a chronic condition of unknown origin, probably toxic and primary in the spleen. It is characterized by splenomegaly, anemia, leukopenia, a tendency to gastric hemorrhage, increased formation and destruction of blood cells, and later by cirrhotic changes with ascites and jaundice.

In 1883, Banti first observed that cirrhosis of the liver and splenic enlargement occurred together, and later described different phases in a detail which is accepted by no one today. That is the reason why "Banti's Disease" is so often referred to as "Banti's Syndrome"—a group of symptoms consisting of anemia, splenic enlargement, hemorrhages, and ultimate cirrhosis of the liver, which it is thought may be produced by a variety of causes.

Banti's theory was that the noxious agent, which is still unknown, was brought to the spleen by the splenic artery, either as a direct toxin or as

Miss Wilms, a student nurse at Royal Jubilee Hospital, Victoria, was awarded the prize donated by the alumnae association for the best nursing care study.

a substance which was there converted into a "splenotoxin." To date no known substance or micro-organism has been proven to play this etiologic role, but until more evidence is available it would seem a retrograde step to abandon the Banti concept entirely. In favor of the separate entity view is the considerable improvement that may follow splenectomy, the existence of splenomegaly before cirrhosis, and the occasional disappearance of an observed cirrhosis after splenectomy. However, it should be accepted that conditions such as cirrhosis of the liver, which produces a long-standing increase in pressure in the splenic or portal vein, can produce a practically indistinguishable picture.

Since there is no commonly accepted explanation of Banti's disease, let us then consider it as a syndrome associated with cirrhosis of the liver. A cirrhotic liver is one in which the liver cells are being replaced by fibrous tissue which causes atrophy, shrinking, and hardening. This condition does not allow free passage of blood through the portal veins so it is dammed back into the spleen and gastro-intestinal tract, with the result that these organs become the seat of chronic passive congestion—that is, they are stagnant with blood and so cannot function properly. Thus the characteristic splenomegaly is produced.

Due to this portal obstruction, portal hypertension develops and, because of its increased pressure, a portion of the blood in the gastric veins escapes through the esophageal veins. These veins become distended, forming esophageal varices, the thin walls of which often rupture. Thus hematemesis is experienced, usually increased by recurrent, profuse gastric hemorrhages. This prominent symptom is probably due to the greatly congested and enlarged spleen reversing the current of the gastric veins to the stomach, causing hemorrhage. In an acute attack these gastric hemorrhages, accompanied by sudden abdominal pain, pallor, weakness, and signs of collapse, may be fatal or

preceded by an acute thrombosis causing death. In the chronic form, however, there are remissions (which are usually accompanied by pernicious anemia) and exacerbations of moderate attacks, varying within periods of from six months to five years, which may persist during an individual's normal life span with minor impairment of health. If these attacks get increasingly worse, the third stage, according to Banti, is ushered in by symptoms of cirrhosis, recurrent painless ascites with occasional jaundice and increased anemia and emaciation. Urobilin is present in increasing amounts in urine and feces. In the terminal stage, exhaustion, fever, and cardiorenal troubles are not uncommon. Death is due to hemorrhage of ruptured varices or an intercurrent infection.

HISTORY

Miss Cox was born in Glasgow, the eldest in a family of three children. They moved to Canada when she was about six years old so that her father could farm. This farm was sold after a few years and they built a home for retirement. Miss Cox has always lived with her father and mother. Her chronic disease has made her incapable of earning a living for herself by preventing her from holding a job for more than one or two years at a time. Her parents appear to be financially comfortable so it is convenient for Miss Cox to look after her parents and their home between her ill periods. She also does odd jobs such as tending children and working part-time at stores, mostly during the rush seasons.

Miss Cox always was healthy during her childhood and could not recall being sick for a day till she was nineteen. That summer she went camping after graduating from high school. It happened that as they were pitching the tent she suddenly jerked up to lift a pole. All at once she grew weak and felt nauseated. Soon she began to vomit profusely and was surprised and frightened to find the emesis a dark red in color. Returning to town immediately she underwent a careful examination by her family doctor who at that time diagnosed her condition as a possible Banti's disease judging by the

palpable, enlarged spleen. The hemorrhage stopped on its own accord in a few hours and after a few days in bed she felt perfectly well again.

Two years later, when she was twenty-one, Miss Cox experienced another gastric hemorrhage—this time more severe, probably from rupture of the gastric veins as well as the esophageal varices. Her family doctor advised a splenectomy rather than run the risk of leaving this condition untreated which could prove fatal in a few years. This operation was performed in 1928 when Miss Cox was twenty-two years old. Despite the operation Miss Cox has had attacks ever since, recurring within periods of from one to three years. It may be possible that the operation has prolonged her life. In this case, since there was no cure resulting, it appears that what was diagnosed as Banti's disease was actually a Banti's syndrome.

A cholecystectomy was performed about three years later which seems to indicate that severe complications were setting in, manifested by such signs as jaundice and urobilin in the stools and urine. This could suggest an early hypertrophy of the liver blocking off the bile ducts or simply a diseased gallbladder. At present, Miss Cox does not seem to be showing any untoward symptoms of gallbladder dysfunction, such as jaundice, clay stools, indigestion, or urobilin in the urine, although the urine has an unexplainable sweetish odor.

I was rather surprised when she revealed to me a symptom that I had never heard of before—bleeding from the umbilicus. Later, when studying this condition, I found that it was not an unusual symptom and resulted from atrophy of the liver. Due to the obstruction, the portal blood finds new channels and the superficial abdominal veins enlarge, notably about the umbilicus, forming the so-called "caput Medusae." This plexus of veins probably ruptures during the excessive retching in a severe attack and a slight red discharge is produced.

The typical onset of one of these attacks is very insidious. Miss Cox states she sometimes feels a fullness in her abdomen before hematemesis. Very often there is just a sudden nausea followed by the vomiting. She then feels acutely ill,

very weak, shaky and pale. If the hemorrhage is prolonged she is taken to the hospital for bed rest and blood transfusions. These are given to bring up the blood volume to normal in order to prevent shock, and to increase the low blood constituents such as the red blood cells, so important for hemoglobin content and oxygen concentration. During her period in the hospital after vomiting ceases she usually gets a severe headache which may be caused by a slight reaction to the blood transfusion. Otherwise she eats and sleeps well and regains her strength quickly. During this last year she has been hospitalized three times, each period being about two weeks. This might indicate a marked weakening of the muscles or veins or the onset of the terminal stages of this condition. This information on Miss Cox was obtained two days after her admission to the hospital when she was feeling much better.

NURSING CARE

Adequate rest—particularly during the acute attack. The patient is then usually hospitalized as Miss Cox was. Anemia follows severe hemorrhage and in this condition absolute rest and freedom from any exertion is essential. The foot of the bed is elevated to lessen the anemia of the vital centres of the body. Added warmth is supplied in the form of extra wool blankets and hot water bottles to the extremities. Warm stimulating drinks are not given since there is bleeding from the gastro-intestinal tract. Patients are ambulatory but are required always to do light work that does not entail emotional or physical strain.

Proper care of the skin: Daily warm sponge baths are beneficial. If the anemia is severe, special care to the skin of the buttocks and heels is necessary to prevent formation of bed-sores. Miss Cox's skin was carefully looked after and no broken areas were noticed—only a slight rash on the elbows due to friction of the sheets. Cocoa butter was applied to soften the rough, red skin and occasional applications of rubbing alcohol to prevent the skin from becoming too soft and thus breaking. Miss Cox has never forgotten the terrible bed-sore

that developed at the time of her splenectomy. Prophylactic measures consist of good skin cleansing, moving about to relieve pressure areas, and gentle massaging as well as medications applied to red areas, such as cocoa butter, alcohol, zinc oxide paste, B.F.I. powder, and so on. Fresh air is an important general health measure so the window was left open as long as possible. Chilling and drafts were avoided by placing a screen between the window and the bed.

Proper care of the mouth and teeth: Ordinary good oral hygiene after each meal, with special care to the mouth during the day, is indicated since these patients often have sores of the tongue, mouth, and pharynx. Miss Cox brushed her teeth after each meal, using her own tooth-paste, followed by an alkaline mouthwash. In the afternoon her mouth was swabbed with a special mouthwash, consisting of equal parts of boric acid solution, glycerin, and lemon juice. Her lips were covered with vaseline which prevented them from drying and cracking, due to dehydration. Sores were not noticed on Miss Cox's gums so this was more of a preventive and comfort measure.

Adequate diet is important with every patient. Miss Cox's diet consisted of fluids for the first two days gradually increasing to soft then light diets as tolerated. Foods easily assimilated and digested were given. Stimulants and coarse foods were avoided because of their irritation to the gastro-intestinal tract. Miss Cox's appetite was poor during the first few days but gradually increased as she began to feel better. Tact and gentle persuasion is often necessary in order to ensure an adequate intake of a balanced diet, but care must be taken not to overload the stomach.

Elimination: The bowels should be made to act daily. Miss Cox was given liquid petrolatum each night to soften the feces and Magnolax, a mild magnesium laxative, in the morning. She had no trouble with her bowels so elimination was easy to regulate. Often an enema is given to ensure "a good cleaning out." Miss Cox was

voiding well since large quantities of fluids were given in the form of milk, broths, consommé, some fruit juices, after the hemorrhage stopped. This was done to avoid dehydration due to great blood loss and to dilute any toxins present since the kidneys may be impaired.

Administration of medicines: These were given as ordered, including blood transfusions. Miss Cox received the following drugs during her illness:

(a) Morphine sulphate $\frac{1}{4}$ when admitted. This hypnotic, a depressant of the central nervous system, was given as a sedative to relax and quieten the nerves and as an analgesic to relieve the epigastric pain. Morphine also helps to control bleeding by calming the patient, thus relaxing blood vessels which aids clotting.

(b) Demerol 50 mg. p.r.n. for discomfort. This white, colorless drug was given intramuscularly occasionally for epigastric discomfort in place of the morphine. It has an analgesic effect similar to morphine.

(c) Codeine gr. $\frac{1}{2}$ was given hypodermically twice for severe headache. It is an alkaloid obtained from opium and is used for its analgesic, hypnotic, and sedative effects.

(d) Vitamin K, the anti-hemorrhagic vitamin complex which aids blood coagulation, was given, 1 cc. q.i.d. intramuscularly, starting the second day of admission, for three days. This probably prevented further bleeding from the ruptured blood vessels.

(e) Miss Cox received 500 cc. of whole blood intravenously each day for four days. These transfusions were very necessary as the blood morphology picture showed that the red blood count was only 1,640,000 when it should normally be between 4 and 5 million per cubic millimeter of blood. The hemoglobin was only 35%. After the fourth blood transfusion the blood morphology was done again. This showed a marked improvement. The red blood cells were 3,660,000 with only slight hypochromia and the hemoglobin was 69%. Blood was taken and retyped each day for the transfusions.

The nurse's responsibility during a transfusion is, firstly, to make sure the patient is receiving the blood designated

for him and when it is started to see that the blood flows through the donor set continuously at the prescribed rate. Secondly, to watch for symptoms of reaction such as headache, chilliness, rapid pulse rate, and a temperature increase of two or three degrees. The patient should always be kept warm, comfortable, and quiet, and if any of the above symptoms, indicating a reaction, are noticed, the transfusion is to be clamped off immediately and the physician notified at once. Often the first voiding after a transfusion is inspected for dark coloring due to gross hemoglobinuria which is indicative of an incompatible transfusion reaction.

HEALTH TEACHING

The importance of good general hygiene with particular attention to the skin and mouth is stressed. The patient must be taught the necessity of not overexerting and of adhering to treatments prescribed by the doctor, regarding diets, medicines, in order to keep as well as possible.

MENTAL HEALTH

As in any chronic disease, patients may tend to be depressed because of their condition. Every effort should be made to keep them cheerful, by providing pleasant surroundings, entertainment such as books and magazines to read and the radio. They

should be led to believe that they are not handicapped seriously, if at all, by directing their interests and possible talents into channels that best favor their condition.

CONCLUSION

This brings us to the end of our medical case study on Banti's disease—a chronic condition for which there is no accepted cause and no proven cure. This was a very interesting study of a medical disease even though it did not involve much actual nursing care. Miss Cox was discharged feeling well and happy and hoping that she would not have another attack soon. However, this seems to be wishful thinking because, looking over the history of this rare disease, we find that these hemorrhagic attacks progressively recur and finally end in death. The prognosis is poor.

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Fact Sheet on Labor Relations

1. *When was the R.N.A.B.C. Labor Relations Program formulated?*

In the fall of 1945, by the Committee on Labor Relations. It was approved without dissent, by the general membership at the 1946 annual meeting of the Association. At the same time the appointment of a Select Committee on Labor Relations was approved, this small committee to implement the Labor Relations Program.

2. *Who pays for the Labor Relations Program?*

The members of the Association, through payment of annual registration fees, a portion of which is devoted to the Labor Relations Program.

3. *Is the program approved by the Canadian Nurses' Association?*

The C.N.A. approved the principle of collective bargaining in 1944 and recommended that nurses utilize the facilities of their professional organizations rather than those of other groups in endeavoring to obtain improved personnel practices.

4. *What facilities are offered by the R.N.A.B.C. to assist nurses in obtaining improved employment conditions?*

- (a) Provincial Placement Service.
- (b) Select Committee on Labor Relations.
- (c) Any employee group of nurses (51% of whom are R.N.A.B.C. members) may name the Association as its bargaining au-

thority. The Association will then apply to the Labor Relations Board for certification.

5. *Who were appointed as members of the Select Committee?*

The registrar of the Association—as convener.

The chairman of the Committee on Labor Relations.

The chairman of the Committee on Legislation.

The director of the Provincial Placement Service.

6. *What are the functions of the Select Committee?*

(a) To help individual nurses or groups of nurses solve their own problems in a business-like manner.

(b) To participate in conferences with nurses and their employers.

(c) To act under certification, as above, as bargaining authority for employee groups of nurses.

7. *When should nurses seek the assistance of the Select Committee?*

Before relationships are strained. Individual nurses or the staff should attempt to solve their problems by first routing them through the proper channel—which is from the immediate supervisor to the director of nursing. If this procedure is ineffectual, assistance should be sought from the Select Committee. The aim of the Labor Relations Program is to prevent problems from becoming serious.

8. *What is the advantage of certification?*

In situations where the employer has been unwilling to give consideration to the wishes of the nurses, the employer is legally required to enter into negotiations with the certified bargaining authority.

9. *Who may use the services of the Select Committee?*

Any registered nurse or group of registered nurses in British Columbia.

10. *Will the members of the Select Committee go out to any part of the province to meet with nurses and employers?*

Yes.

11. *How may nurses obtain the assistance of the Select Committee?*

By writing, telephoning, or visiting the provincial office of the Registered Nurses' Association of British Columbia, 1101 Vancouver Block, Vancouver.

12. *Is the threat of mass resignation or strike used in seeking to obtain improvements in salaries and conditions of work?*

At the 1948 annual meeting of the Associa-

tion the following resolution was adopted by the general membership:

"WHEREAS, The use of threats of mass resignations of nursing staffs to obtain objectives violates the principles of professional service and, in the opinion of the public, constitutes strike action; therefore be it

"Resolved, That the R.N.A.B.C. go on record as disapproving of such action by any registered nurse or group of registered nurses in this province."

13. *Has the R.N.A.B.C. outlined general recommendations concerning working conditions, salaries, etc.?*

Yes. Each year since 1945, in annual meeting, members of the Association have discussed and approved desirable recommended personnel practices for the coming year and copies are sent to hospitals, public health agencies, medical and hospital associations throughout the province as well as to R.N.A.B.C. members.

14. *What items are included in the recommended Personnel Practices?*

Recommendations regarding hours of work, statutory holidays, vacation, sick leave, residence, board and laundry, salaries, definitions of positions, marital status, permanency and temporary employment, staff health program, pension plans, employment contract, and a recommendation that the personnel practices be subjected to study annually.

15. *Where may copies of the revised recommended Personnel Practices be obtained?*

From the R.N.A.B.C. office.

16. *Is collective bargaining compatible with the professional status of nursing?*

Yes, since through it nurses can work together to promote their economic security without jeopardizing standards of professional practice.

Many parents feel that talking back must be ruthlessly suppressed. Impudence cannot be tolerated; however, many parents and teachers will not even allow a child a word in his own defence or an attempt to explain. Yet when they are offended they urge the child to stand up for himself. The importance to state his case, to assert his rights is too great to confuse it with "no talking back." Talking back, in the sense here defined, avoids intolerable frustration which results when the child is prohibited from saying anything about his feelings.

Book Reviews

Operating Room Technique, by Edythe L. Alexander, R.N. 765 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price \$11.00.

Reviewed by Mary Ogilvie Berry, Operating-Room Supervisor, Homoeopathic Hospital of Montreal.

Although each individual hospital has its standard procedures set up, the fundamental techniques are most clearly and concisely presented in this volume. Most textbooks fail to cover the many simple problems facing the student and young graduate interested in surgery. In the opening chapters, the supervisor will be interested in the plans for the teaching of students and helpful outline of general management.

The chapter dealing with the history of asepsis is informative and interesting and must have been compiled only after extensive research. It is most instructive. In Chapter 8, suturing material is discussed in detail and most valuable are the illustrations of instruments, with lists for different types of operations performed in the majority of operating-theatres, instructive explanation of the nomenclature, valuable descriptions of the surgeon's operative procedure, with accompanying medical illustrations clarifying each step followed.

This book should be included in all operating-room libraries and great credit is due Miss Alexander for her patience and for the hours devoted to providing valuable guidance to surgical nurses. After many years of experience, I found this book to be interesting and inspiring.

Tests and Measurements—Applied to Nursing Education, by Hyman Krakower, Ph.D. 179 pages. Published by G. P. Putnam's Sons, New York. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Price \$3.85.

Reviewed by Murial Archibald, Statistical Worker, Canadian Nurses' Association.

"Tests and Measurements" is really a basic textbook for those interested in the formulation, preparation, etc., of tests and in the interpretation of data as applied to nursing education. It is a loose-leaf book which may

prove useful when wishing to add to or take from its pages.

The text starts with the assumption that the reader knows little or nothing about its subject, and guides her with simple language and well-chosen examples one step at a time. At the end of every chapter are sufficient problems to make the learner familiar with the words and problems to which she has been introduced. Words and phrases such as "percentile graph," "mode," "median," "standard deviation," and "coefficient of correlation" will no longer be mysteries. However, this is not a book that can be read in a day but one that needs to be digested slowly and thoroughly.

Administrators, directors, teachers, and supervisors who have time, in a planned program of nursing education, will find it of inestimable value in student selection and student accomplishment. It would make an excellent guide for a course in "Tests and Measurements" in a program of supervisory staff education.

Pediatrics and the Emotional Needs of the Child, edited by Helen L. Witmer. 180 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1948. Price (in U.S.A.) \$1.50.

Reviewed by Miriam L. Gibson, Instructor of Nurses, Hospital for Sick Children, Toronto.

This book is a discussion of the value of some psychiatric training for the pediatrician; the great need for more doctors to understand the emotional as well as the physical needs of a child. Up to the present time chief emphasis has been placed on the physical care and treatment. The question was asked as to whether there should be more child psychiatrists or should pediatricians be trained to meet the child's emotional needs. As this is only a report of a conference, the question is not answered. This book is of value in stimulating thought "in the hope that it may serve to strengthen in some slight degree the integrative forces in medicine."

Many interesting and enlightening points are brought out in this discussion. Common sense plays an important part in training both the pediatrician and the parents as shown by Dr. Spock's discussion:

"During the first year of life it takes a pretty disturbed mother to make a disturbed child. The baby enhances the mother's ego rather than challenges it. But it is easy for things to go wrong during the second year. Unfortunately, at this time the pediatric visits become less frequent. Also, the pediatrician finds himself poorly trained to handle the psychological problems that so frequently occur. Toilet-training conflicts develop during the second year because the baby now has an ego and begins to have feelings about bowel function."

This book would be of little value to the nurse and very definitely is not intended as a text. However, it is a very interesting and stimulating book to those who have had some background in pediatrics and psychiatry and it is essentially a book intended for the expert in these fields of medicine.

The Second Forty Years, by Edward J. Stieglitz, M.S., M.D., F.A.C.P. 317 pages. Distributed in Canada by Longmans, Green & Co., 215 Victoria St., Toronto 1. 1946. Illustrated. Price \$1.98.

Reviewed by Jessie G. Morrison, Matron, Veterans' Home, Edmonton.

"The Second Forty Years" is a book that needed to be written. Since it has been written so effectively, it should be read by a large portion of the general reading public. Every age group, from the early twenties upward, would be benefitted by a thoughtful perusal of its pages.

In the early chapters, the author explains in a concise and lucid manner the process of aging biologically. The following chapters deal with the hazards inherent in aging, discussing the means by which they may be circumvented. It is worthy of note that the author stresses the fact that the *means lie within the individual*. He reiterates that longevity in itself is not enough, that it carries with it great responsibility—the responsibility of the individual to maintain health, independence, and so conduct his life that his maturing years will be fruitful and useful.

The place of the senior citizen in present-day business and industrial spheres is also discussed. Advantages and disadvantages attendant on his employment are pointed out. The advantages would appear to be in his favor.

The great problem of caring for our rapidly increasing, elderly, indigent population is placed before the reader in such a manner

that it cannot avoid arresting attention. This was the author's purpose.

The material is well organized and ably presented. A summary at the end of each chapter is of great assistance in bringing pertinent facts into sharp focus. A list of recommended collateral reading is found at the conclusion and should be most worthwhile for those interested in pursuing this engrossing—and very personal—subject further.

Although the author intended this book to be a "popular" presentation, the many technical terms and phrases found throughout, would seem, to this reader, to put it out of that class of literature.

Blakiston's New Gould Medical Dictionary. Editors—H. W. Jones, M.D.; N. L. Hoerr, M.D.; A. Osol, Ph.D., with the co-operation of an Editorial Board and 80 contributors. 1294 pages. Published by Blakiston Publishers, 105 Bond St., Toronto 2. 252 illustrations on 45 plates—129 in color. 1949. Price—Textbook edition, \$8.50; Thin paper edition, \$10.75; DeLuxe edition, \$13.50.

One of the most useful and comprehensive books to reach the *Journal* offices is this new, large dictionary. Backed by an imposing roster of 80 contributors, this book contains thousands of terms used in all branches of medicine and allied sciences, illustrations, and tables. Forty-five plates—some in color, some in black and white—include pictures and sketches of anatomical subjects, fractures, dislocations, micro-organisms, etc. Pronunciation of difficult words is made relatively simple by the use of syllable division and accent.

Any dictionary's value is dependent on the use that is made of it. The completeness of this volume's information should warrant it a place in every hospital. To permit easy access by students and graduates alike, it might even be included in the standard equipment of each ward.

The Hospital in Contemporary Life, edited by Nathaniel W. Faxon, M.D. 288 pages. Published by Harvard University Press, Cambridge, Mass. Canadian agents: S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1949. Price \$6.25.

Reviewed by Bertha L. Pullen, Superintendent of Nurses, Winnipeg General Hospital.

This is a book of historical appreciation, showing the contributions and effects of economic, educational, social, and scientific progress on human betterment.

Although the various chapters seem irrelevant and deal with widely varying aspects of medical and hospital practice, education of the doctor, components of human suffering, growth of medicine and its relation to science and the place of the hospital in the social order, they all emphasize the prime factors of human relationships, spiritual attitudes in professional practice, and the importance of doctor-patient relationships based on the brotherhood of man.

The book accentuates the lag between the facilities for medical hospital care and society's demand for better community health; and the dangers of a premature and immature state medicine to the finest, fullest, and richest development of medical and hospital care for humanity.

This is not a textbook but a careful analysis of the imbalance between social needs and medical hospital development. It is interestingly written, very readable, and should be widely read by hospital administrators, doctors, and nurses.

Aids to Male Genito-Urinary Nursing, by John Sayer, S.R.N., D.N. 130 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Illustrated. Price \$1.25.

Reviewed by M. Mullen, formerly on the staff of the Royal Victoria Hospital, Montreal.

One emerges from a casual perusal of this book with a firm conviction that the author presents an invaluable text for students and post-graduate nurses covering the various points of knowledge regarding the anatomy and physiology of urological nursing.

The author has compiled a concise teaching and reference book, covering the pre- and post-operative treatments and nursing care of the patient with prostatism, nephritis, renal calculi, cystitis, and other urological symptoms. An excellent section is written on dietary treatment and the drugs to be used.

Of particular interest are the excellent illustrations of the delicate instruments and the various types of catheters which are used in described urological procedures and operations. The clear anatomical sketches

shown throughout the book help us with a clearer mind to understand the knowledge fundamental to the study of urology.

This textbook, written mainly for the use of nurses, is in a pocketbook form, concise and easy to read, and will prove to be an ideal reference book to be carried about and referred to from time to time.

A Handbook for the Assistant Nurse, by Mary E. Swire, S.R.N., S.C.M. 308 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1949. Illustrated. Price \$2.75.

This book is written as a handbook for the assistant nurse in England. It covers a wide field and many nurses may feel that it goes beyond what a nurse's assistant should be allowed to undertake. The material is not well organized and there is a vagueness or incompleteness about much of the information which lessens its value.

Some of the methods of procedure are anything but modern. Differences in customs and conditions and the difference in the scope of work of a nursing aide, apart from other factors, make it inapplicable for use in Canada.

This book would be of little value either as a handbook or on the shelves of a reference library for those in Canada engaged in assisting nurses in the care of the sick.

Nursing Sisters' Association

Members of the *London Unit* held their annual dinner at the Highland Golf Club in November. The president, Hilda Collier, of Westminster Hospital, welcomed the 39 nurses present. The vice-president, Bessie McKenzie, proposed the toast to the King.

The 18th annual meeting of the *Ottawa Unit* was held on Armistice Day at the Chelsea Club. Rev. John Stewart, former padre with the 3rd Division and at present rector of St. Margaret's Church, Eastview, was guest speaker at a luncheon which preceded the business meeting. The executive for 1950 includes: President, Evelyn Pepper; vice-presidents, D. Percy, Mrs. P. J. Philpott; secretary, F. I. Garnett, 310 Holmwood Ave.; treasurer, M. Phillips, 7 Carlotta St., Eastview; membership secretary, D. Dent, 54 Somerset St. W.; flower convener, A. McNicol; social conveners, Mrs. J. H. Stitt, J.

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1. Lapin, J. H.: J. Pediatrics 32:110 (February) 1948.
2. Hotzman, W. S.: J. Pediatrics 32:11 (January) 1948.

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1950



THE CANADIAN NURSE

C.N.A. BIENNIAL
CONVENTION

June 26-30

Vancouver, B.C.

NURSING SERVICE
1950

Florence Emory



CLINIC TEA-PARTY

See page 84



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Swelling.....	2 plus.....	0.....	5 days
Limitation of Motion.....	3 plus.....	0.....	11 days
Impairment of Functional Capacity.....	3 plus.....	0.....	11 days

*"Succinate-Salicylate Therapy in Arthritis" by M. M. Szucs, M.D., Ohio State Medical Journal, Oct., 1947. Your copy of this article will be sent on request, together with professional literature.

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The Canadian Nurse

VOLUME 46

NUMBER 2

FEBRUARY, 1950

NEW PRODUCTS.....	86
ECHOES FROM THE FOOTHILLS.....	J. S. Clark 93
ANESTHESIA.....	J. M. Wishart, M.D. 95
PRE-ANESTHETIC PREPARATION.....	E. Barnett 96
SOME CONCEPTS OF PSYCHIATRIC NURSING.....	E. S. Goddard, M.D. 98
ADVENTURE IN NURSING.....	M. M. MacLaren and E. M. McDowell 100
NURSING SERVICE 1950.....	F. H. M. Emory 103
CONSTRUCTION OF HOSPITALS.....	B. Beyer 107
EVALUATION OF SCHOOLS OF NURSING.....	112
NEW RESIDENCE OPENED.....	N. D. Fidler 114
THE PATIENT ON A BRADFORD FRAME.....	M. E. Pickens 115
THE STRYKER FRAME.....	E. J. Fenwick 117
INTEGRATION OF HOSPITAL AND COMMUNITY SERVICES.....	S. Holmes 119
FAMILY SERVICE IN A GENERALIZED HEALTH AGENCY.....	M. Willis 122
MADEMOISELLE RADIO 1950.....	S. Giroux 128
NURSING PROFILES.....	130
TRENDS IN NURSING.....	132
ORIENTATION ET TENDANCES EN NURSING.....	136
WORK CONFERENCES.....	138
METHEMOGLOBINEMIA.....	I. E. MacLachlan 140
BOOK REVIEWS.....	150
NEWS NOTES.....	152
OFFICIAL DIRECTORY.....	160

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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Between Ourselves

To many nurses Florence H. M. Emory is best known for her book on public health nursing. To those nurses who have attended the University of Toronto, she is the kindly counsellor, with a rich store of knowledge of nursing affairs and activities. To those of us whose nursing experience includes the black years of the depression, Miss Emory stands out as the person who, as president of the Canadian Nurses' Association, 1930-34, took the lead in the many important developments of that period. It was during her tenure of office that the first survey of nursing education in Canada was successfully concluded. She envisioned the possibilities for enlarging the scope and usefulness of *The Canadian Nurse* when she sponsored the employment of the first full-time editor and business manager.

In this issue Miss Emory's facile pen has given us her picture of the problems and possibilities that face nursing in this year, 1950. Read her article with a consciousness of the background of knowledge and authority with which she speaks. This material was given as an address at a refresher course held under the auspices of the School of Nursing of the University of Toronto last autumn.

* * *

Our guest editor this month, Jean S. Clark, president of the Alberta Association of Registered Nurses, is a native daughter with as broad a perspective in nursing as the far expanses of her prairie province. Graduating in 1940 from the University Hospital in Edmonton, she completed the work for her bachelor of science in nursing degree the following year at the University of Alberta. After four years of experience in public health nursing, she was awarded a Rockefeller fellowship for advanced study at Johns Hopkins University, Baltimore, Md. Returning to Alberta, she became director of the public health nursing division with the Alberta Department of Public Health. When the federal health grants to the provinces were announced in 1948, Miss Clark was relieved

of her provincial duties to participate in the activities of the Alberta Health Survey Committee. The account she has given us of the nursing activities in her province brings a picture as warming as the Chinook that blows over her beloved foothills.

* * *

Have nurses anything to contribute to the architects who design our hospitals? When they have to walk nearly the equivalent of a city block to fetch and carry for their patients, many nurses feel that they would like to condemn the architect to just one day of hurrying back and forth between a utility room that is inconveniently placed, a kitchen that has few of the modern inventions that ease a housewife's chores, and a 15- or 20-bed ward. Bianca Beyer, who had had practice in remodelling an old school building into a workable, efficient, well-planned hospital, gave the architects of Toronto some valuable pointers in the course of an address which she delivered to them. Her article, an adaptation of this address, may strengthen the hands of many nurses during this period when the tremendous surge of hospital construction is adding new units in so many communities.

* * *

We would like to call your attention to the article on the Student Nurse Page. **Methemoglobinemia** is a relatively unknown disease and Miss MacLachlan has given us a good description of it, together with an understanding of the essential nursing care.

* * *

Peterborough, Ont., has a very active chapter. Last season they sponsored a refresher course, several of the papers for which are included in this issue. Sister St. Agnes, operating-room supervisor at St. Joseph's Hospital, gave a demonstration of the various **anesthetic agents** currently being used and, together with Dr. Wishart and Miss Barnett, showed the set-up of the anesthetic bed and table and the reception of the patient following anesthesia.

* * *

Our Cover—We are indebted to Aubra Cleaver for permission to use this photo from her collection, taken and presented to the Child Health Centre, Goderich, Ont., by Ann Wurtele.

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Description—'Histadyl' (Thenylpyramine Hydrochloride, Lilly) and 'Surfacaine' (Cyclomethycaine, Lilly):

Lotion M-64 contains in each 100 cc. 'Histadyl' 2 gm., 'Surfacaine' 0.5 gm., calamine 8 gm., zinc oxide 8 gm.

Cream No. 6 contains 'Histadyl' 2%, 'Surfacaine' 0.5%, is a non-irritating, hypo-allergenic base.

Indications—Allergic dermatoses associated with severe itching and discomfort, burns, abrasions, dermatological lesions, solar erythema, insect bites. Cream No. 6 is especially suggested as a local analgesic in pruritus ani et vulvae.

CAFERGONE Tablets

Manufacturer—Sandoz Pharmaceuticals Ltd., Montreal.

Description—Each tablet contains ergotamine tartrate 1 mg. and caffeine 100 mg.

Indications—Migraine and tension headache.

BACIDRIN

Manufacturer—The Upjohn Company, Toronto.

Description—Antibiotic nasal decongestant in dry form. When contents of one bottle are dissolved in water to make 15 cc., each cc. of the resulting buffered isotonic solution contains:

Bacitracin.....	200 units
Ephedrine hydrochloride.....	5 mg. (0.5%)
Myristyl-gamma-picolinium chloride.....	1:10,000

Indications—Upper respiratory infections associated with inflammation and congestion of nasal mucosa, as in the common cold; infectious rhinitis, nasopharyngitis, and sinusitis.

Administration—As nose drops or nasal spray every 2 to 4 hours. The solution is stable for 1 week if stored in refrigerator. Dry form is stable for 1 year at room temperature.

NEO-ANTERGAN EXPECTORANT

Manufacturer—Poulenc Laboratory Limited, Montreal.

Description—Neo-Antergan Expectorant combines the well-known antihistaminic Neo-Antergan and Ephedrine in an aromatic, pleasant tasting excipient. 1 teaspoonful (4 cc.) of Neo-Antergan Expectorant contains:

Neo-Antergan.....	20 mg.
Sodium citrate.....	43 mg.
Tr. cocillana.....	0.36 cc.
Promoform.....	2 mg.
Ephedrine Hydrochloride.....	10 mg.
Ammonium chloride.....	80 mg.
Menthol (crystals).....	0.4 mg.

Indications—Asthma, cold, or bronchitis of allergic origin, vasomotor rhinitis, or any other respiratory complaint associated with an allergic condition.

Administration—Adults: 1 to 2 teaspoonfuls every 3 hours, or as directed by physician. Children: Half dose.

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They do not cause vaginitis or erosion, and cannot block the flow.

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*West. J. Surg., Obstet. & Gynec., 51:150, 1943; J.A.M.A. 128:490 1945; Am. J. Obst. & Gynec., 48:510, 1944, etc.

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REPORT No. 1

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All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.



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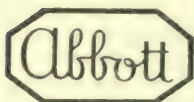


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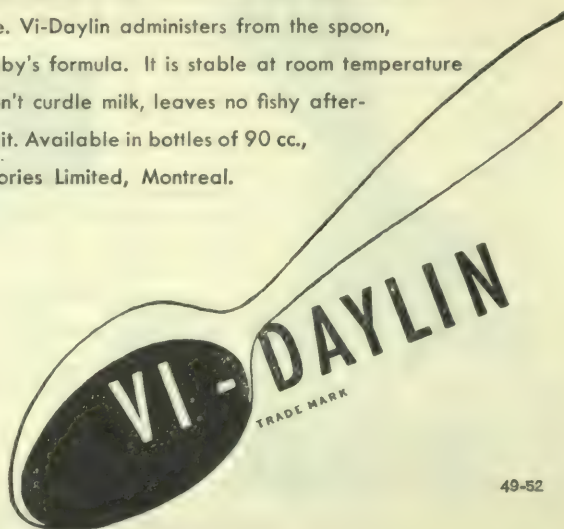
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Vitamins A, D, B₁, B₂, C and
Nicotinamide, Abbott)



49-52



The

CANADIAN NURSE

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MONTREAL, FEBRUARY, 1950

Echoes from the Foothills

Average reading time — 2 min. 6 sec.

I WELCOME THIS opportunity of greeting the nurses of Canada on behalf of all the members of the Alberta Association of Registered Nurses. We extend to you our very best wishes for 1950.

It was with regret that we accepted the resignation of Miss E. Bell Rogers, our registrar for four years. 1949 commenced with a new registrar at the helm—Mrs. Clara Van Dusen. This was the first year our increased membership fee of \$8.00 was in effect, made necessary by the anticipated increase in C.N.A. and I.C.N. affiliation fees which we wished to be in a position to meet and by the operating deficit of the past two years. Despite the increase in fee, our present active membership of 2,177 is the highest in the history of the association.

1949 marked the first year that associate memberships were granted, at an annual fee of one dollar. To date, our associate membership totals 871. These members are eligible to vote and become committee members and are kept informed of association activities through the A.A.R.N. *Newsletter*. The *Newsletter* featured paid advertising for the first time in the

June issue and this venture has produced a revenue in eight months of over \$700.

1949 marked the organization of the Banff and Jasper chapters of the association, the first two to be formed. Considerable interest and activity may soon result in similar organization in other centres.

Over a year ago, the A.A.R.N.



Goerts, Edmonton

JEAN S. CLARK

accepted with pleasure a request from the Alberta Health Survey Committee to appoint a liaison committee which would be available to discuss nursing problems. Our committee presented its recommendation in person to the Health Survey Executive and also accepted an invitation to sit with the full Survey Committee for an afternoon session on nursing.

We are gratified that a number of projects of benefit to nursing have been approved under the Dominion Health Grants. Perhaps it would be of interest to the other provinces to describe these projects briefly.

In the 1949-50 fiscal year to date, 40 nurses have been provided with assistance under the Professional Training Grant to pursue post-graduate work as follows:

Public health nursing—1st level ..	21
Public health nursing—2nd level ..	1
Teaching and supervision	6
Operating-room techniques	3
Refresher courses	3
Obstetrical nursing	2
Clinical supervision	2
Pediatric nursing	1
Hospital administration	1

In addition, funds were provided under this grant which made possible an institute on ward management and one on child guidance and development at the University of Alberta.

In the spring of 1949 an affiliation

program in tuberculosis nursing was inaugurated at the Central Alberta Sanatorium, Calgary, through funds from the Tuberculosis Grant. Three schools of nursing in southern Alberta are participating in this plan.

During the fall of 1949 a program was launched to provide affiliations in psychiatric nursing at the Provincial Mental Hospital, Ponoka, through funds from the Mental Health Grant. Two schools of nursing are already sending students for affiliation.

A project under the General Public Health Grant made possible a study of nursing services in Alberta throughout the summer months. Miss Rae Chittick, past president of the C.N.A., conducted this study for the Health Survey Committee. Through the same grant, money has been made available to offer a six-weeks course in hospital administration to matrons of small hospitals. It is anticipated that this course will be offered at the University from January 30 to March 10. Money has been made available to provide teaching aids in schools of nursing and also to assist additional nursing aides to undertake the ten-month training course at the school in Calgary.

There are many more developments toward which we are working. We look forward to 1950 with optimism!

JEAN S. CLARK, M.P.H.
President, A.A.R.N.

Notice of Executive Meeting

The Executive Committee of the Canadian Nurses' Association will meet on March 9, 10 and 11, 1950, at National Office, 1411 Crescent St., Montreal.

The Scottish Board of the Royal College of Nursing reported a most successful, if rather unusual, party at which the Student Nurses' Association Unit of Leith General Hospital presented the Board's Education Department with a first-class skeleton, complete in a handsome case.

Three comments made by the examiners following one series of registered nurses' examinations in Ontario are applicable everywhere and warrant consideration:

"1. Spelling is again a source of concern. Errors were common in such words as fever, vein, doctor, skull, stomach—and more difficult words were distorted almost beyond recognition.

"2. Abbreviations were scattered throughout the papers but not quite so freely as in the previous examinations.

"3. Students seem to be increasingly aware of the importance of health teaching in their work."

—R.N.A.O. News Bulletin

Anesthesia

J. M. WISHART, M.D.

Average reading time — 5 min. 36 sec.

PREMEDICATION is not of great importance except in highly nervous patients and then it seldom works. Many anesthetists do not give any premedication. Atropine, however, helps to stop mucus and secretions in the mouth.

Most anesthetics now are a combination of several drugs to get the best effects of each one with none of the bad effects—i.e., spinal with pentothal; pentothal, curare and nitrous oxide or cyclopropane; local and pentothal or cyclopropane. This also results in fewer post-operative complications, less nursing care, and happier patients. Anesthetics are divided roughly into two groups—regional and general.

REGIONAL ANESTHETICS

Regional anesthesia includes local, field block, nerve block, caudal, spinal, and peridural blocks. Regional block means the interruption of the nerve reflex at the periphery. The drugs most commonly used for this purpose are procaine, pontocaine, and nupercaine. Procaine is used mainly for nerve blocks and local. It is most toxic. Pontocaine and nupercaine are used mainly for spinal and peridural blocks. Pontocaine is the least toxic in the doses in which it is used.

Barbiturate premedication will offset the convulsive tendency of all cocaine derivatives.

Apart from spinals, regional anesthesia is used only for relatively minor procedures. Spinals give maximal relaxation and complete anesthesia and so are considered by many surgeons to be the best. However, they may produce permanent nerve damage unless great care is taken in their administration.

Nursing care is limited to protecting the affected parts from burns, laceration, and pressure which the patient cannot feel. The use of very

low spinals and peridural anesthesia will gain favor in obstetrical cases because they give prolonged relief from pain without the attendance of a doctor. This is particularly true of continuous peridural anesthesia which is very new, but which has been used to give anesthesia constantly for one week.

GENERAL ANESTHETICS

Substances used cause anesthesia by acting on the brain. They give relief from pain and relaxation by affecting the body as a whole.

Pentothal is a short-acting barbiturate which offers a pleasant induction, free from fear of the mask. Recovery is free from nausea and vomiting. It is given intravenously by intermittent or continuous injections. Post-operative nursing care is of short duration but very exacting as the patient may develop laryngeal spasm and cyanosis very quickly and, therefore, must be watched constantly. Treatment for such a spasm is suction and oxygen, and curare.

Curare is given intravenously and produces relaxation but no anesthesia. It acts on the junction of nerves and muscles and so permits a lighter plane of general anesthesia. The effect of curare has usually worn off before the patient returns to the ward but, if not, he may become cyanosed as the respiratory muscles may be paralyzed. Treatment is artificial respiration; 100 per cent oxygen and prostigmine, which is a specific antagonist.

Procaine may be given intravenously. It relieves pain in traumatized tissue, such as burns, operative incisions, etc. It is given post-operatively to reduce the amounts of depressing sedation, and may be used to supplement other anesthetic agents during an operation.

Ether is inhaled through a mask. It is the safest drug for inexperienced

anesthetists. Its main drawbacks are a slow unpleasant induction, post-operative nausea and vomiting. It is seldom used now, except in children, by trained anesthetists. It is the only drug which safely relaxes the uterus for versions, etc.

Chloroform is also inhaled. It is little used due to the danger of liver damage. Induction is pleasant and there is less post-operative nausea and vomiting.

Cyclopropane is inhaled but due to its cost there must be a closed circuit gas machine. It is used only by trained anesthetists due to the danger of cardiac or respiratory arrest. Static electricity causes fatal explosions so woollen blankets must be kept away from the patient's mouth and nose. Cyclopropane is usually used with pentothal and curare in combined anesthesia.

Cyclo shock is the result of a building up of carbon dioxide in the respiratory and blood system. Treatment of this condition is with vasopressors, oxygen, but not external heat. Post-cyclo cerebral irritation may occur in which the patient is irrational due to cerebral anoxia and excess of carbon dioxide. Treatment is morphine and oxygen.

Nitrous oxide is a weak inhalation type of anesthetic. It is used in obstetrics to ease early pains. It is also used extensively as an adjunct to pentothal to intensify and prolong its action.

Vinethene and ethyl chloride are used mainly as an induction for open ether. They are given via the open mask.

RECOVERY ROOM

This special accommodation is essential to handle post-operative patients until they are fully recovered from the anesthetic. It should be equipped to handle any emergency and the nurse in charge must be trained and authorized to carry out emergency treatment.

TRANSPORTATION

Those in charge of transporting the unconscious patient must maintain an adequate airway and be gentle. After all nose and throat operations the patient should be in the Sims's position in transit and then the semi-prone in bed. After all other operations, the patient should be placed in the Sims's position.

Pre-Anesthetic Preparation

E. BARNETT

Average reading time — 2 min. 6 sec.

ON ADMISSION to hospital, a patient anticipating an operation is usually apprehensive and emotionally upset. Fear predisposes to shock and may make the administration of the anesthetic difficult. The nurse can do much to allay the dismay by building up the patient's confidence in the doctors and hospital personnel. She makes a personal contribution by her

own quiet, interested manner. It is a great moment in the patient's life and the nurse should recognize it as such. At this time, she should endeavor to assist him to utilize all his religious resources. It is good psychology to explain to the patient just what will be his own part in his ultimate recovery and to stress the importance of patience and co-operation to ensure a successful start and outcome to the operation.

The physical preparation would include signature of consent, ade-

Miss Barnett is a member of the nursing staff at St. Joseph's Hospital, Peterborough, Ont.



A Co-Operative Venture

Progress in medical education would be without benefit to man and his various ills if there were no progress in nursing education. Newer methods in treatment require to be reviewed constantly by the nursing profession. Particularly is this true in psychiatry where most progress in the treatment of patients has been achieved during the period of greatest scarcity of nurses. Nurse educators will have to put forth greater efforts to catch up in numbers of nursing personnel and to provide instructors well versed in newer methods of training. Some provinces of Canada and states of the U.S.A. require affiliation with psychiatric hospitals at an undergraduate level. These provinces and states lack sufficient supervising nurse instructors in psychiatry. A decision of the University of Western Ontario School of Nursing to take up nurse instruction and nurse supervision in

this field is, therefore, of prime importance at this time.

The Treatment Services of the Department of Veterans Affairs is pleased to co-operate with the University and to provide more hospital and clinical facilities for the training of psychiatric instructors and supervisors. This is further evidence of liaison between the universities and the Department of Veterans Affairs and will provide benefits to both students and the patients alike. The patients will obviously benefit from having the more efficient care of our trained nurses. The nurses will be able to undertake psychiatric work at a higher level and also learn to adjust to personal needs and problems better by the training they have received.

W. P. WARNER, M.B.
Director General of Treatment Services

Some Concepts of Psychiatric Nursing

E. S. GODDARD, M.D.

Average reading time — 4 min. 48 sec.

FOR MORE YEARS than we care to count, physicians and nurses treated diseases and left the patient to recover by himself. While it is readily agreed that most illnesses are self-limiting, some real strides have been made in reducing the length of the patient's stay in hospital. Newer drugs, anti-biotics, and biological preparations have lowered the mortality rate of numerous illnesses which were previously considered fatal. Physical medicine with physiotherapy and occupational therapy have further reduced the patient's hospital stay. The final chal-

lenge remains to be taken up; that is, the treatment of the individual as a sick person, and the avoidance of separation of mind-body.

Man is a complex, highly integrated organism as shown by the physiological functioning of the central nervous system, the autonomic nervous system and the endocrine system. If sickness intervenes with his way of life he gets sick as a whole. He must also get well as a whole or retain some evidence of physical or emotional trauma. In addition, it is reasonable to expect that if the patient is given an opportunity to recover as a complete individual recovery will take less time. This makes imperative the consideration

Dr. Goddard is director of psychiatry at Westminster Hospital, London, Ont.

of the emotional aspects as an integral part of treatment. The most fortunate patients are those free from worries and fears; the patient who can relax and is calm and composed has a greater chance for recovery. That desirable state may come from the patient himself, from his outlook or philosophy of life. It can be fostered by the hope and confidence of the nurse.

A good working relationship between patient, nurse and physician is of the utmost importance in medicine and surgery. In psychiatry this relationship reaches its greatest height. Here nursing in the field of human behavior becomes a challenge for tact, kindness, human understanding, keenness of observation and clarity of description. The nurse has every reason to apply the principles of science, psychology and sociology to actual clinical situations. She must be well prepared from the standpoint of information, skill and attitudes to use these concepts in psychiatric nursing.

A background of experience, self-knowledge, and self-discipline is required of the nurse in order to cope adequately with the emotional problems of others. This implies emotional maturity and adequate adjustment in personal problems of living. Emotional maturity enables her to make decisions and accept responsibility. It enables her to be adaptable in work that calls for continual changes in attitudes, in meeting patients with complex moods and set patterns. Adaptability carries with it an equanimity that enables her to keep her own thoughts and emotions in proper balance.

Another requirement is the ability to meet effectively the patient's needs. In order to understand a little of the patient's inner turmoil, some discernment of the patient's feelings and needs is necessary. Understanding the patient is the first step in obtaining his confidence; satisfactory interpersonal relationships are impossible until this is attained. Possession of discernment or wisdom will enable the nurse to keep her own

thoughts and feeling states in balance and give her stability and perspective. An objective and tolerant attitude is invaluable and will assist the nurse in projecting herself into the patient's problems and will enable her to understand them. The patient is entitled to his emotional outbursts as they are characteristic responses in disturbed thinking. Lack of reasoning and judgment on the part of the nurse will do considerable damage and cause the loss of essential contact and rapport.

Every effort should be made to establish a relationship with the patient. This can best be done by anticipating his needs and satisfying them. These include adjustment to environment, knowledge of his habits, stimulation of wholesome reactions, attention to trifles, searching for interests and planning conversations or activities. By knowing the patient, his needs can be anticipated and at the same time satisfied.

As the patient's various needs are anticipated and satisfied, a question in meeting the different patients' problems develops. Disturbed, boisterous or otherwise difficult patients can be managed with tact and positive suggestion. Each new situation constitutes a challenge to be met and not a situation to be avoided. At the same time one learns to measure successes and apply them at a later date. From a growing fund of experience, handling the patient's problems consists of more than telling him what to do. There are certain periods where compromise is an important adjustment although sometimes a difficult one for the nurse. In any service where routine is defined, details clarified and simplified, it is easier for the nurse to insist on regularity than to subordinate herself to the patient's way. Co-operation and reciprocity are just as important for the nurse as for the patient and often mean the difference between contentment and contention. Compromise is a willingness to see with long-range vision, that which is in the patient's interest. Manipulation of the routines around the patient

and improvisation if needed will produce techniques which will show a tendency to accelerate recovery. In essence, psychiatric nursing is an intelligent approach built around inductive reasoning and tolerance.

The above concepts, however, should not be reserved for psychiatric nursing alone. They are applicable to all branches of nursing, since it has been amply demonstrated that there can be no physical illness without mental and emotional disturbances. The frightened child in a hospital ward, the seriously ill post-operative patient, the bedfast chronic

invalid, or the accident victim who is not sure if he will walk again, all require more than mechanical performance of routine nursing duties. There is no substitute for kindness, consideration, promptness in response, alertness, the inspiring of hope and confidence.

Nursing is truly a social science operating in the field of human behavior. Where else can such rewards in terms of contentment, tranquility, relief from tension and freedom from fear be obtained for such a small amount of tact, kindness, patience and understanding?

Adventure in Nursing

MIMA M. MACLAREN and EDITH M. McDOWELL

Average reading time — 6 min. 24 sec.

AT WHAT point may the nurse consider herself the finished product? Directed to any nurse, this question is invariably answered with a smile of amusement. No nurse today would have the temerity to suggest that she could ever know all there is to know about nursing. Special fields are too numerous, changes in method and treatment too rapid to permit any illusions on that score.

Yet have the fundamental needs of patients changed? Will they ever change? Will the patient eventually come to view himself as a statistic? Will his illness, for him, ever cease to be of paramount importance? Surely this is asking too much of human personality! It would seem that to understand what is happening to him will always be of primary importance to the patient; that his need to work with those who seek to help him toward his greatest

possible recovery will always be present. To achieve this he may always need to be helped to discover or rediscover goals in living.

Nursing has always stood in direct relationship to these intangible aspects of patient need. The nurse today seems to have lost ground in this respect because of two factors.

Her need to be well-informed and skilled in the increasingly specialized techniques of treatment.

Her inability to keep pace with an increasing body of knowledge with respect to human personality.

Perhaps the greatest unmet need expressed by the general practitioner of nursing in considering shortages in her basic preparation lies in the area of understanding human behavior and the relationship of mind and body in health and disease. It is significant, but no cause for reassurance, that this criticism is not characteristic of nursing alone, but is held in common with other professions which seek to help people.

Fortunately the nursing profession has unchallenged access to the experience field. It is within that field that nursing education may find the

Miss MacLaren directs the nursing service at Westminster Veterans' Hospital, London, and Miss McDowell is dean of the School of Nursing, University of Western Ontario, also in London.

means of overcoming the present impasse. The busy and overburdened administrator of nursing service is aware of the problem but finds herself unable to stem the tide. The nurse-educator, too, sees the problem, and recognizes how ineffectual subject matter may be if significant relationships are not found in the experience field. When these two people find the means of facing the problem together they are enabled to plan hopefully for the attainment of a possible solution.

The University of Western Ontario School of Nursing and the Westminster Veterans' Hospital, London, for more than a year have been actively concerned with working out a plan whereby the facilities of the hospital might be used to the fullest extent by graduate nurses desirous of securing further guided study and experience. We have been fortunate in having the support and interest of the W. K. Kellogg Foundation in working through this project. Its grant to the School made it possible to provide for the training of teaching personnel and in-service education. In the light of shortages in preparation expressed by many graduates it was logical to look to the psychiatric field as the first point of departure. After examining its potentialities it seemed to us that the psychiatric hospital had developed certain traits in patient care which are not as readily discerned in the general clinical field. Some of these may be cited here:

1. The nurse in the psychiatric field finds it necessary to function as a member of a team, and to discover the nature of her role in that relationship, as well as the role of co-ordinator of the contributions of other professional workers.
2. The nurse becomes aware in this field that she is primarily concerned with group work.
3. The nurse discovers that the emphasis is placed upon the patient and his constructive resources, because these determine the probability of his favorable response to such treatments as insulin and electric shock, sub-insulin therapy and psychotherapy. Thus she is provided with

an opportunity to re-evaluate the relationship between manual nursing techniques and procedures and the intangibles of patient care.

4. The nurse discovers that an increasingly large percentage of mentally ill patients recover. Therefore, the plan of patient care must provide for rehabilitation.

5. The nurse discovers that she, herself, is not a catalyst in the nurse-patient situation. A growing understanding of herself as a person accompanies an awareness of the fact that the introduction of her own personality into the situation of mental illness may have either a positive or negative value to the patient's recovery.

The educational program in the psychiatric field must make the most of these traits and, in addition, plan to provide for certain favorable conditions for the student. The following principles form the base upon which we hope to build the student's learning experience:

1. All administrative, supervisory and teaching personnel must have an awareness of the student's need for sympathetic guidance in making the essential re-adjustment to the new field, so that traumatic results may be avoided, and professional development may be assured.
2. In her professional adjustment and guidance in acceptance of the basic concepts underlying good psychiatric care, one must come to terms with the matter of time, since guidance through experience spells professional growth, in contrast with the acquisition of mere factual material. This places a limit upon the number of hours per day to be spent in the clinical field, calls for the use of the patient-assignment method, and relief from the burdensome pressures of too much work to be done.
3. Individual reading, seminars, individual and group conferences, all in relation to the student's experience in patient-assignment, must be provided within the working day. Without these, the experience may lose its value—indeed, it may result in miseducating the student.
4. There must be a desirable ratio of field-guides to students, in order that

individual and group guidance may be possible, and field experience yield its maximum of constructive educational value.

5. The students' own health and energy must be safeguarded from a too-great "service load" which would render a satisfactory educational program impossible, but assurance should be given that their contribution to patient care has positive value.

6. Provision should be made for pleasant living arrangements, comfortable home-like residence, good meals, attractively served, with provision for recreation and hobbies.

7. The surrounding social climate must be created by all professional workers in the agency, and should give evidence

that it has been worked out co-operatively in relation to the principles which they profess to have given acceptance.

8. Lectures and libraries, for the provision of sound knowledge have their place, but should sub-serve the educational aims to be achieved. "... true and lasting learning is not a matter of isolated, functionless 'study,' but is the outcome of a living participation in investigation and research prompted by need and stimulated by interest in a job worth doing."¹

REFERENCE

1. Mearns, Hughes. *The Creative Adult. Self Education in the Art of Living*. 1940. Doubleday, Doran & Co. Inc., New York.

EXPERIENCE IN PSYCHIATRIC NURSING

The University of Western Ontario School of Nursing, in co-operation with Westminster Veterans' Hospital, London, and other community agencies, will offer to Graduate Registered Nurses a programme of study and guided experience in **Psychiatric Nursing**, to commence **on March 1, 1950**.

For further particulars write to:

**The Dean, University of Western Ontario School of Nursing
London, Ont.**

Increased Birth-Rate

The recent upsurge in the birth-rate among women past the prime of reproductive life is attributable, in large part, to the high level of economic prosperity and to the desire of many women to bear the children they felt they could not afford to have during the depression. Another factor has been the increase in the proportion of married women at the later child-bearing ages. Still another point, often overlooked, is the marked progress which has been made in safeguarding mater-

nity. It is likely that older women, and particularly those bearing their first child, have been encouraged to undertake child-bearing by the reduction in the hazards of maternity. The maternal mortality at ages 35 to 39 has dropped 65 per cent between 1940 and 1947. Among women in their early 40's the rate has been cut in half, and even at the ages past 45 the reduction has amounted to about 35 per cent.

—M.L.I.C. *Statistical Bulletin*

There is a breadth of life as well as length, and there is no area in a straight line.

—IRVING FISHER

Nursing Service 1950

FLORENCE H. M. EMORY

Average reading time — 7 min. 12 sec.

IN APPROACHING A TOPIC of this nature there is one possible advantage in having attained professional maturity, namely, that experience over many years makes possible a comparison of the situation 30-35 years ago with that of today. Hence, through a comparison of that which was with that which is, it is possible to contrast the past and the present with that which should be and thus to determine the nature of the challenge which confronts us today as professional workers. Let us glance at nursing services in, say, 1912-1915.

THE PAST

Looking back upon the first decades of this century one is conscious of the fact that community health service as a whole was in the earliest stages of its development. Emphasis was given to cleaning up the environment through the application of sanitary measures destined to improve the general living conditions of the population; new health knowledge, released gradually through scientific discovery, had little effect upon community life.

These years were characterized by much illness and many deaths from preventable causes. Typhoid fever, for instance, was rampant in the fall of the year with ward after ward in many of our hospitals given over to the care of patients with this disease. It is recalled that their nursing care was an exacting discipline. The incidence of tuberculosis and deaths from it took a heavy toll also. Because of limited sanatorium facilities many of these patients were cared for in a tent in the backyard until such time as a hospital bed became available. Diphtheria, too, cut short the lives

of many infants and children; oftentimes, in a choking condition, they were admitted for hospital care too late to be effective. In those years scores of infants died from intestinal causes, particularly in the late summer and early fall. Many of them were taken to hospital in a weakened condition without hope of recovery. Moreover, in a period before the full value of prenatal care was realized, too many mothers were lost at childbirth. One could go on giving further emphasis to the general situation but enough has been said to show that unnecessary illness and deaths were a common occurrence in the Canadian community.

A GROWING SENSE OF RESPONSIBILITY

Glancing at community health machinery during this period there can be sensed an increasing responsibility on the part of governments for these conditions and for their prevention. On the municipal level many communities were appointing a full-time medical officer of health whose initial work emphasized the cleaning up of the environment. This was the period of the purification of water, of the pasteurization of milk, of "swat the fly" campaigns. The public health administrator, in presenting his budget to the city council, would say, "You can get the health you pay for . . . there will be fewer babies in coffins if the estimates are passed." Provincial governments were also taking initial steps which at a later date would result in more health care for the rural community. This era pre-dated the establishment of a federal department of health so that governmental interest and a resultant expenditure of funds was confined largely to the local municipality. Such expenditure was, indeed, small, by far the greater proportion of the medical dollar being spent on illness.

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But with all of this the era of health education was emerging with some nurses already employed by municipal departments of health and visiting nurses engaged in a morbidity service in many centres. Special preparation for the task given the nurse in this setting was not offered in Canada, the basic course of the hospital school providing the only training available.

HOSPITAL SERVICES DEVELOPING

Both the in-patient and out-patient departments of our hospitals were developing and rendering yeoman service but the nursing schools attached to the hospitals lacked standards concerning inspection, curriculum guide, prepared instructors, supervisors and head nurses, and registration examinations.

It should be re-emphasized that at this time post-graduate and basic courses in nursing were not offered by our universities. Certain nurses, wishing to gain further preparation, were obliged to enrol in newly organized one-year courses in the United States.

ATTITUDES

Great emphasis was placed upon curative service and a wide gap in both thinking and action existed between the curative and preventive fields. In fact, in these earlier days there was no general acceptance of the true value of prevention. A nurse, for instance, entering a hospital school in order to gain the preparation necessary for the practice of preventive nursing, maintaining that interest throughout, and upon graduation undertaking health department work, was considered by her classmates to be novel, if not a bit queer. In the organized profession it was the era of sections, of a tendency to separate into groups in terms of a specialty or special interest. Programs were so arranged that much discussion took place in section meetings, with few sessions when common problems were considered by all.

Those associated with the early development of community health work remember the fear of most

people for the hospital. Much persuasion was necessary in order to convince the laity of the value of hospitalization. In fact, prevention in the fields of both medicine and nursing was a new emphasis; the health ideal a new concept. Hence, the need for interpretation, for salesmanship in order that the public might be convinced of the value of health activities and thus provide increasing funds for their support. Briefly stated these were some of the factors influencing the nursing services of this period.

THE PRESENT

And now let us examine certain aspects of nursing service today. In all fairness to the situation, it must be stated that, compared with the earlier period, there is much evidence of growth with much room for encouragement.

THE EXPANSION OF HEALTH SERVICES

Perhaps at once the most obvious and the healthiest factor in the current situation is the overwhelming demand from the public for full-time health services in both urban and rural areas. In fact, the initial effort of the pioneer has been rewarded so that current expansion is limited largely by the lack of trained workers to undertake the task. Moreover there is a marked increase in the use of hospital facilities. Prepayment plans have increased the demand for hospital beds to such an extent that the average stay in hospital is shortened with post-hospital care in the community greatly expanded. A natural concomitant of this growth has been the increased pressure upon nurses to meet the challenge of an ever-widening range of activities. This constitutes a considerable factor in the present shortage of nursing personnel. Along with all of this, and a matter which is influencing present practice more than is realized, is a growing recognition of the inter-relationship of the preventive and the curative in medicine and in nursing. The progressive concept is that

of health restoration, health protection, and health promotion: a concept of continuity of service within and without the hospital and of unified effort in promoting the community's health service; a concept not of different fields and different goals but of one field and one goal with differing emphases in reaching it. Associated with this there has come a renewed emphasis upon the economic and social aspects of medicine, with appropriate repercussions in both the medical and nursing fields.

IMPROVEMENT IN PREPARATION FOR SERVICE

It is unnecessary to go far afield in order to be convinced that there has been much development in this area. The Nurse Registration Acts of the several provinces laid the foundation for the setting of standards for both education and practice. Nor is this all. There has been remarkable progress in the establishment and growth of education for nurses within the university. Post-graduate and undergraduate courses are offered in many of them and at least a portion of this work reveals an honest effort to place nursing education on a sound professional basis. Moreover, from governmental and private sources, there is considerable financial aid for those wishing to undertake such courses through scholarships and bursaries available in increasing numbers and amounts.

Along with all of this can be felt the stimulating and co-ordinating influence of the organized profession within our own boundaries. The Canadian Nurses' Association is affording the type of leadership which emphasizes the similarities rather than the differences in the various fields of nursing, striving constantly to bring into relief the common interests of all nurses. Thus there is more understanding and practice of co-ordinated effort. There is an increasing awareness, too, that a shortage in professional nurse-power can and must be supplemented by the contribution of the auxiliary worker. To this end the organized profession

has sanctioned and influenced the preparation and practice of this group. But not alone the auxiliary worker has received attention. The demonstration school in Windsor, under theegis of the organized profession, is testimony at once to the fact of changing needs in meeting professional demands in service, and to the method of experimentation in determining how best those needs can be met. There is much evidence, therefore, of a fuller realization of the demand for well-equipped workers at various levels and for women capable of giving the type of leadership in administrative and teaching posts commensurate with that offered by other professions.

INCREASED FINANCIAL SUPPORT

Underlying and underlining all of this effort is the financial assistance in the form of health grants offered by the Federal Department of National Health and Welfare in implementing step by step a comprehensive health program for Canada. Already the stimulus of this money, administered through provincial governments, is felt in furthering nursing service and nursing education. Surely a new day for nursing is dawning when the evening newspaper of a great Canadian city could, in its editorial column, make the following comment: "A public training program for nurses would appear to be one of the key measures to ensure the success of the national health plan."

CHANGE IN THE INTERNATIONAL OUTLOOK

Those who are sensitive to changes of thought and attitude have been quick to sense development in countries beyond our own borders and outside the North American continent. Much progress has taken place in a solution of similar problems with varying degrees of accomplishment. In the field of health services England is in the forefront with perhaps the the most inclusive plan for community health ever attempted. As for preparation for nursing, the pioneer efforts of certain European countries

have afforded inspiration for the establishment of the education of nurses on a sound educational basis through the instrument of a nursing school administered and financed quite independently of the hospital. Of this Finland is a notable example.

Further, there is ample evidence that the organized profession in its international relationships is on the march. Witness the eagerness with which countries seek to qualify for membership in the International Council of Nurses. The influence of this organization in raising the standards of nursing in affiliated countries is conceded. More than formerly, too, the Council realizes the need for unified, co-ordinated effort. This is seen in the current effort of committee chairmen to seek, jointly, information desired for the carrying on of their work through the preparation of a composite questionnaire to be sent to all national associations. The action of the recent conference in Stockholm, through which the Florence Nightingale International Foundation has come within the overall administration of the International Council of Nurses, will result in co-ordinated effort in nursing education and make possible the preparation of leaders, as well as the development of research inherent in professional growth.

Still another source of encouragement lies in a relationship between the World Health Organization and the International Council of Nurses whereby advice is sought from the professional group in nursing matters. A will to meet changing conditions in a new and better way was an outstanding feature of the meetings of the Council in Stockholm. There was evident an open-minded approach to problems, with an emphasis upon the value of experimentation in their solution.

THE CHALLENGE

Finally, we come to grips with the heart of this paper—that is, with integrity and courage to attempt to determine what is the challenge confronting nursing in the year 1950.

As an aid to our thinking let me raise certain pertinent questions:

1. Do we who are members of the profession really believe in nursing as an essential community service—a social utility?

2. Are we convinced that professional nursing is a significant part of the total nursing picture but not the whole picture?

3. Do we hold the belief that professional nursing requires workers whose performance will compare favorably with that of other professional groups?

4. Are we willing to try new methods, devise new plans, support new projects which purpose to meet the need in a fuller, better way?

5. Are we willing to follow the path along which scientific study will lead, that is, with an open mind and an undaunted spirit to seek what is best and, having found it, to conserve that best?

6. Are we ready to struggle, to strive, to sacrifice for professional truth and to accept the consequences of finding the truth. It will mean professional adjustment and change accompanied by professional discomfort. For it is impossible to be professionally comfortable in a period so characterized by change. Are we willing to accept professional discomfort in order that the *community and its people may be comforted*?

What then is the challenge? We have looked briefly at the past and the present. We have asked some pertinent questions concerning professional attitudes and the future. The challenge is clear. Through conviction and well directed effort we must narrow the gap between what we have and what we need; between what we know and what we do so that the public may be given the fullest and the richest service of which we are capable. The challenge is epitomized in three quotations:

From Greek literature—"Nothing is permanent except change."

The writings of Mr. Justice Holmes—"Certainty is illusion and repose is not the destiny of man."

Mark Twain—"Loyalty to petrified opinion never yet broke a bond or freed a human soul."

Construction of Hospitals

BIANCA BEYER

Average reading time — 17 min. 36 sec.

IT IS A pleasure and a responsibility to present the views of a nurse in regard to hospitals. It is a personal viewpoint based on my experience within hospitals, on observation of hospitals in other countries, and on the opportunity I have had within recent years to assist in converting a school building into a 130-bed hospital for the care of the chronically ill.

CONSULTING A NURSE

If I were asked to name one aim it would be to encourage architects to include a nurse in the consultations held prior to the planning of any hospital. The experienced nurse thinks in terms of the individuals and activities within the building and her advice would be invaluable in building or reconverting a hospital. Such advice should not be overlooked or ignored. Hospitals exist, primarily, to serve patients and their needs deserve the first consideration. However, it is the nursing staff that is responsible for service to patients 24 hours a day and 365 days of the year. Therefore, the needs and comforts of the nurses in the working situation must also receive due consideration if the patients in turn are to receive satisfactory attention and care. The same is true of all other workers in a hospital where combined effort results in satisfaction or dissatisfaction.

I have had an opportunity to nurse in a large teaching hospital, in old remodelled and new buildings, and in all services. For one of these years, 1938-39, I was granted leave of absence to complete a post-graduate course in nursing administration at the University of London in England. The course included visits of observation to hospitals in London and on the Continent—in

Belgium, Germany, Poland, Latvia, Finland, Sweden, and Denmark. At this time my chief interest was in nurse education rather than hospital administration and, therefore, the nursing school rather than the hospital building was my main concern, but general impressions of the hospitals were also noted. In January, 1944, I was appointed superintendent of a hospital that did not even exist. The Civic Administration, to meet the need for additional accommodation for chronically ill patients, had decided to convert a school into a hospital and the architect had requested that a nurse be appointed to assist with the plans. This was my introduction to blueprints and to a situation where a nurse's opinions had been sought and were welcomed. The opportunity, which was presented to co-operate in an effort to produce a hospital that would be satisfactory to patients and staff, was a challenge and a privilege. I certainly learned a tremendous amount from the architect and he may have learned something about a nurse in the hospital situation from me.

UNSATISFACTORY FEATURES

A strong impression gained during my years in a large general hospital was how unsatisfactory the lay-out of a hospital can be from a nurse's point of view. I refer mainly to the oldest parts of the building and particularly to the large public wards when I cite a few of the unsatisfactory features:

1. The great distances between the patients and the service sections of the wards—namely, the utility rooms, the pantries, the linen rooms, offices and storage areas, and, therefore, the great distances for the staff to walk, resulting in wastage of time and effort.
2. The inadequacy of the utility rooms without bed-pan sterilizers and storage cupboards, with some shelves too high for

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the nurses' use, and an absence of shelves beside sinks and sterilizers where they were most needed.

3. The lack of running water in the wards.

4. The placing of beds with the heads to the windows.

5. The unsatisfactory lighting and placing of electrical outlets.

6. The absence of cubicle curtain screening and privacy for patients.

In contrast to the old large wards there was also a new private patients' pavilion where the contrast between bare necessities and luxury was particularly striking, emphasizing anew the distinction between the poor and the rich. It is my belief, as a nurse and as an individual, that hospitals should be planned to provide care of equal quality to poor and rich alike. My observations in England and on the Continent only served to strengthen this belief where it was more commonly accepted and applied.

EUROPEAN OBSERVATIONS

In England I had a very good opportunity to observe the pavilion types of hospitals and to realize my preference for the block style of architecture to conserve heat, space, and effort.

The most practical, satisfactory, and beautiful hospitals anywhere were in the Scandinavian countries, particularly in Sweden and Finland. Outstanding impressions were of spaciousness, brightness, attractiveness, thoughtfulness in planning for the comfort of patients and staff, and for the care of poor and rich alike. Rooms were large, bright, and cheery; nursing units were small to minimize walking, in patient care; equipment was of good quality and complete, planned for the care of all citizens equally, and the exteriors and surroundings of the buildings were as attractive as the interiors.

LEARNING OPPORTUNITY

In my capacity as superintendent of a hospital which was opened twenty months after my appointment, a real learning opportunity was presented to me during the period of

preparation. Perhaps you would be interested in some of the convictions gained from this experience:

1. The first and foremost is expressed by two quotations:

(a) "Quality is not an accident. It is the result of intelligent planning."

(b) "Recollection of quality remains long after price is forgotten."

The lesson learned was that the cheaper price usually indicates poorer quality and costlier maintenance and that it pays to purchase good quality for satisfactory and lasting service.

2. That it is a grave mistake to have hospital service dependent on *one* elevator. Through bitter experience I have learned that one elevator cannot be expected to serve both for freight and passengers in the same building, particularly when the serving of meals is dependent on it, and when it is automatically controlled and, therefore, more sensitive and "temperamental."

3. That cubicle curtain screening is a necessity for patient privacy and staff satisfaction.

4. That color therapy and pleasing appointments are morale builders.

5. That an attractive exterior should be given equal consideration with a pleasing and satisfying interior.

COMMUNITY HEALTH CENTRE

From the foregoing general statements I should now like to transfer my thoughts to a specific situation and then to details applicable to the specific situation.

A hospital building committee should be interested in the details of hospital construction that appeal to a nurse. More and more, in the field of public health, emphasis is being placed on prevention rather than cure. Therefore I would prefer to name such a building a community health centre. The centre would include a wing for in-patients who require hospital treatment and care, as well as public health facilities and facilities for out-patients' examination and treatment, including clinics, private offices for doctors and dentists, x-ray and physiotherapy departments. We should take for granted that the health centre would

be built only after a complete and careful survey of the district's requirements had been made and its situation and type determined to meet the needs.

I will not attempt to describe the type of building this community health centre should be or how it should be constructed. Rather, I will confine my remarks to observations regarding the wing for in-patients—the hospital as we call it today. If this hospital is required to meet all the needs of the community in which it is situated, it should be planned to care for all types of patients, including medical, surgical, obstetrical, the mentally ill, the chronically ill, and those with communicable diseases. Therefore, included in its facilities must be an operating-room suite, a delivery room suite, a nursery, an isolation wing, rooms for patients and all adjunct areas required for service to patients, with the necessary accommodation for staff.

Satisfactory care of patients and ease of operation for the staff are inseparable. *Good hospital service and patient satisfaction are directly dependent on the satisfaction of staff in the working situation and in living conditions.* I cannot overemphasize the importance of this statement. So often these days one reads that graduate nurses are not willing to include menial tasks in their care of patients. I am prepared to deny such a statement and to say, with definite knowledge, that the graduate nurse is prepared to give service to patients in any form that it may be required, including the most menial tasks. However, the graduate nurse is an intelligent individual and she does object to the performance of her duties in situations and surroundings that are unsuitable, where she wastes both time and effort in the midst of unnecessary confusion, and where such conditions exist due to lack of understanding and foresighted planning.

SUGGESTIONS OF VALUE

May I, now, make some observa-

tions that might be of value to architects in planning a building in which a nurse would find satisfaction and pleasure in nursing a patient and, therefore, one in which the patient would receive full benefit. The following factors would definitely appeal to nurses:

1. A building of fire-proof construction.

2. Suitable entrances and exits to allow for the necessary control of traffic and limited to give a feeling of security. One entrance for the general public.

3. A pleasing exterior and well planned surroundings, with delivery entrance, parking area, admitting entrance, garage and gardens suitably placed in relation to outside appearance and to the windows of the building.

4. An attractive entrance lobby that offers the public an immediate impression of cleanliness, order, and friendliness. Ample and comfortable waiting-rooms, cloakrooms, and washrooms for visitors. Well placed information desk and public telephone. Well placed and attractive direction signs.

5. Concealed wiring and plumbing.

6. Acoustic treatment of ceilings in service areas.

7. Wide corridors and stairways, possibly 12 ft.

8. Wide doorways suitably protected by metal edging, to allow for ease in moving beds and conveyors, possibly 4 ft.

9. High ceilings and a good system of ventilation—12 ft.

10. Large low windows which can be cleaned from the inside, with picture windows wherever possible.

11. Good and adequate lighting, indirect wherever possible, with fixtures which are easy to clean, without ceiling lights in patients' rooms and with night lights.

12. A satisfactory heating system.

13. At least two elevators.

14. A dumb-waiter from the central supply room.

15. A soiled linen chute leading directly to pick-up carts.

16. A vacuum-controlled chute for the shaking of mops.

17. Floors of terrazzo or tile with a curved base and a raised ledge to prevent the scraping of walls by furniture and

conveyors. In corridors, a central strip of linoleum, for ease of walking, chosen to blend with the color scheme in the area.

18. Terrazzo blocks or colored tiles on walls of all service rooms, such as kitchens, pantries, bathrooms, utility rooms, cleaners' rooms, etc., to a height of 4 to 6 ft., depending on fixtures and height of ceiling.

19. Muroleum or other protective, washable material on the walls of corridors, offices, patients' rooms, day rooms, dining-rooms, etc., to a height of 3 to 5 ft.

20. The application of color therapy throughout the entire building, planned to suit the situation and the functions in the area. Color therapy improves patient welfare, staff morale, and public goodwill.

21. Adequate storage space for supplies that must be stored in preparation for the work that must be done, with suitable accessories to encourage cleanliness and order.

22. Storage space for wheel-chairs and stretchers.

23. Stainless steel sinks, tables, shelves, and equipment wherever possible, for cleanliness, ease of maintenance, good appearance, and endurance.

24. Rounded or slanting surfaces for ease in maintaining cleanliness.

25. Solariums.

Concentrating now on the patients' units, I would consider the following factors to be of importance in patient care:

1. Single, 2-bed and 4-bed rooms.

2. The number of single rooms, 2- or 4-bed rooms would be dependent on the type of service to be rendered, e.g.: *Single rooms* for: private patients, seriously ill or noisy patients, isolated patients. *2-bed rooms* for: semi-private patients, convalescent patients. *4-bed rooms* for: less expensive accommodation.

3. In all rooms beds should be placed parallel to the exterior walls.

4. Each bed should have at least 80 sq. ft. floor space and for each patient there should be: a clothes' closet, call light, double utility outlet, bed light or shaded wall light.

5. Each room should have running water to allow the medical and nursing

staff to maintain good technique. Rooms for private patients should have accommodation which provides for emptying, flushing, and cleansing of the patient's individual bed-pan and with a bed-pan holder or cabinet. Rooms for isolated patients would require similar toilet accommodation and a sub-utility room, possibly between two units. For isolated patients there would be required, also, a separate pantry with adequate facilities for sterilization of trays and china. Less expensive accommodation—a 4-bed room—might be arranged with a toilet room and sub-utility room between two rooms, thereby lessening the nurse's steps.

I fully realize that additional plumbing and fixtures increase initial costs but they are essential for good service, to satisfy patients and staff, to maintain cleanliness and to prevent cross-contamination. These reasons are more important than cost.

6. Furniture and equipment should be similar for all patients, the need based on the need of the sick person, not on the amount the person is able to pay. Therefore, essential equipment such as beds, bedside tables, over-bed tables, and chairs should be standardized. If desirable in certain rooms, unnecessary but attractive items such as rugs, floor lamps, and easy chairs may be added.

7. Service areas should be centrally located, well planned to meet the requirements of the particular unit, and well placed to eliminate unnecessary walking. By service areas, I refer to:

Nurses' stations or charting desk room. Medicine cabinet room with sink and running water and with adequate and suitable storage space for drugs and narcotics. Nurses' workroom with sterilizers, work table, and storage cupboards. Unit pantry for preparation of nourishments. Linen rooms. Flower rooms. Cleaners' closet, suitably ventilated and equipped.

8. Centrally located dietary department for: preparation of meals, setting of trays, washing and sterilizing dishes.

The advantages of centralization are: Concentration of equipment and staff with necessary supervision; standardization of service; removal of noise from patients' areas.

Electrically heated conveyors should be used for serving meals and each tray should be served individually. Only in this way can hot foods be served hot and individual consideration given, resulting in the patient's enjoyment and appreciation. The sick person's appetite needs to be tempted and all of us are creatures of habit in our likes or dislikes for certain foods. Meals, quite definitely, retard or hasten recovery and, therefore, must be given primary consideration in patient care.

I have spoken in general terms about certain factors in hospital construction that would appeal to me, and I have been more specific in regard to the preparation of the patients' accommodation to allow for satisfactory nursing care. Now, having stated previously that "good hospital service and patient satisfaction are directly dependent on satisfaction of staff in the working situation and in the living conditions," I should like to speak briefly of staff accommodation necessary to produce that satisfaction:

1. Administrative offices, including business office, spacious, bright, cheerful, with quiet surroundings and the necessary privacy for concentrated work and an incentive for good work.

2. A board room. (May be combined with superintendent's office.)

3. Cloakrooms, washrooms, and rest-room facilities, suitably equipped and furnished.

4. Lecture room, classroom or both, to meet the requirements of educational programs.

5. Locker rooms—spacious, well-lighted, well-ventilated, and suitably equipped with mirrors, benches, and adjoining washrooms.

6. Cafeteria in conjunction with attractive and comfortable dining-rooms. Food is important in patient care. It is also important in producing staff satisfaction, to give staff the strength and endurance for perpetually arduous duties concerned with the care of the sick.

7. Provision for accommodating the resident medical staff including: Single bedrooms with clothes' closet and a basin with hot and cold running water;

suitable bathroom with tubs, showers, wash-basins, and toilets; a sitting-room.

Accommodation should be attractively decorated and comfortably furnished and should be as distant as possible from patient accommodation, preferably in a separate wing or building.

8. Nurses' residence, including plans for:

- (a) The educational department, according to the type of educational program, and based on accepted educational requirements.

- (b) Recreational facilities including those for: *Open-air activity*—tennis courts, roof garden; *interior athletic activities*—recreation room, gymnasium, swimming pool; *entertainment*—drawing-room, sitting-rooms, kitchen facilities, reception rooms, public cloakrooms and washrooms.

- (c) Housing accommodation, according to the need of the occupants, including single bedrooms with clothes closet and a basin with running water. Suitable bathroom with tubs, showers, wash-basins, and toilets, or single rooms with private baths or connecting baths. Suites of two or more rooms with private baths. Guest-room or rooms with private baths. Each room should have an individual key for door and closet. Community laundries, sewing-rooms, and kitchenettes. Suitable windows, flooring, wall finishes, lighting, and call systems.

- (d) Necessary accessories. Health centre and infirmary. Central linen room. Janitors' and maids' closets. Storage rooms, including trunk rooms. Elevator. A direct connection with the hospital. Comfortable, suitable, and attractive furnishings.

Throughout my discourse concerning the hospital and the nurses' residence, it has been obvious that recommendations have been made without thought of cost. However, the recommendations have been based on necessities and the adjuncts which are required to produce general satisfaction and pleasure and, therefore, I offer no apologies for disregarding cost. Also, my statements have been frank and it is my hope that plain speaking will cause you to realize that a nurse does have some opinions

which may be of value in making a hospital suitable and attractive for patients, staff, and the general public.

In closing, I should like to repeat and emphasize two earlier remarks that "the hospital exist primarily to serve patients" and that "the experienced nurse thinks in terms of the individuals and activities within the building." Therefore, she bases her opinion of its suitability on the care she is able to render the patient, and on the ensuing benefit the patient receives. Only when satisfaction has been derived can it be transmitted.

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Evaluation of Schools of Nursing

FOUR YEARS AGO this month, the report of the Committee on Nursing Education, containing details relating to the proposed accreditation of schools of nursing in Canada, was published. There, the purposes of accrediting were set out as being:

1. To stimulate the improvement of nursing education by defining desirable standards for nursing schools.

2. To assist prospective nursing students in selecting nursing schools, and to supply information to vocational guidance workers in high schools.

3. To get information which would be useful in educating professional and lay groups regarding nursing education.

4. To guide the provincial associations which are responsible for the standard of nursing education in each province.

The possibilities of setting in motion a national program of accreditation were carefully studied by the Executive Committee of the Canadian Nurses' Association during the spring of 1946. It seemed a desirable project:

Though the hospitals of Canada have been graded for many years by the American College of Surgeons, the relative status of individual schools of nursing has been a matter of hearsay. It was proposed that an Accrediting Committee should be set up which would evolve "standards for the evaluation of nursing education and practice" and, with these as a guide, would visit "those schools which voluntarily seek recognition and identification with this activity."

It was an ambitious proposal that would necessitate trained personnel and a considerable expenditure of time and money. Finally, the following resolution was adopted in June, 1946:

Inasmuch as funds are limited and other projects seem to be more urgent, further action in regard to the Accrediting of Schools of Nursing be not taken at the present time.

There the matter has lain, so far as the Canadian Nurses' Association was

concerned, until the past few months. Its revitalization now is due to two main factors:

1. A program of *evaluation* of schools of nursing, as distinct from the broader project of accreditation, has been developed by the Canadian Conference of Catholic Schools of Nursing.

2. The Canadian Nurses' Association has been sponsoring the Metropolitan School of Nursing at Windsor, Ont., since January, 1948. It is recognized that this is a special venture to demonstrate the practical operation of an independently financed school of nursing. Nonetheless, the C.N.A. Executive Committee has become increasingly aware of the desirability of developing some adequate tool for the evaluation of its school.

What is an evaluation program? How does it get started? What is done with the findings? Is such a program feasible for the C.N.A.?

In his introduction to the Manual, which was prepared for the guidance of the Sister examiners, Rev. Hector L. Bertrand, S.J., director and adviser to the Canadian Conference of Catholic Schools of Nursing, reviewed the background of the program which saw seven Sister examiners visit and evaluate 24 schools of nursing in Canada. Father Bertrand wrote:

In August, 1946, a group, composed of the Sister examiners and the members of the Canadian Conference of Catholic Schools of Nursing, met in Montreal for a period of 15 days. The purpose of this meeting was (1) to study the possibilities of evaluating our Catholic schools of nursing throughout Canada and, (2) to prepare our conference members and our examiners for this tremendous task . . . The schools (evaluated) located in 19 different cities, 8 different provinces . . . were under the direction of 19 different sisterhoods and represented a total number of 2,695 students.

So that every nurse in Canada will have an opportunity to learn the facts regarding a program of evaluation before the matter is again discussed at the C.N.A. convention, a series of short articles will appear in consecutive issues. Miss Margaret Street, convener of the subcommittee

studying this matter, has prepared the article for March. Sister Denise LeFebvre of Montreal, who played an active part in the aforementioned evaluation program, will contribute the April article. They will offer suggestions as to how a similar program might be initiated by the C.N.A., building on the splendid foundation that has already been laid. By co-operative effort and understanding, it may be possible to launch a full-scale program of evaluation for all schools of nursing in Canada.

Florence Nightingale International Foundation

Now that the International Council of Nurses has accepted full responsibility for the Florence Nightingale International Foundation, a new committee has been set up to make plans for the future. As hitherto, the activities of the Foundation are to be of an educational nature. Its principal objectives will be to promote research, to create a centre of information on educational facilities, to establish and stimulate the award of scholarships, and to develop a section of the Library of the International Council of Nurses dedicated specifically to Florence Nightingale.

Canada will be represented on the new committee that has been named by the I.C.N. by Miss E. Kathleen Russell, director of the University of Toronto School of Nursing. The other members so far nominated include: Mrs. R. Louise McManus, director of the School of Nursing Education, Teachers College, New York; Miss Mary I. Lambie, director of the Division of Nursing in the Department of Health, Wellington, N.Z.; Miss Venny Snellman, director of nursing education, Department of Health, Helsinki, Finland; Miss Marjorie Duvillard, director of the Bon Secours School of Nursing, Geneva, Switzerland; Miss Ellen Broe, educational director, Post-graduate School, Aarhus University, Denmark. The League of Red Cross Societies has nominated Miss Yvonne Hentsch, their chief nurse, as their representative. The first meeting of this committee is to be held in London on March 1 when future plans will be drafted.

New Residence Opened

In Windsor, Ontario, on Saturday, November 26, the new building for the Demonstration School, in association with the Metropolitan Hospital, was opened at 2240 Kildare Road.

Readers will recall that as part of their contract with the Canadian Nurses' Association, the Metropolitan Hospital and the city of Windsor undertook to put up a building,



The residence

to be used for the School during the demonstration period, and that in the meantime a house would be converted so that the School might commence in January, 1948.

Last autumn the very fine new building was completed, and the formal opening arranged for the last week-end in November. On Saturday the official groups concerned were represented at the opening ceremonies in the recreation room. These were attended by representatives of the city of Windsor, the School Board, the Canadian Nurses' Association, the Canadian Red Cross Society and its Windsor branch, the Metropolitan Hospital, the Registered Nurses' Association



Bright classrooms

of Ontario, the Minister of Health and Department of Health, Ontario.

The representative of the Mayor presented the golden key to Mr. J. E. Carruthers, chairman of the School Board, who responded in an extremely fine manner, taking the opportunity of emphasizing some of the fundamental principles of the School. Miss Agnes Macleod spoke, both as first vice-president of the Canadian Nurses' Association and as chairman of the Demonstration School Committee; also Col. Bishop, chairman, Central Council of Red Cross, and the Hon. Russell Kelley, Minister of Health, Ontario. A telegram of congratulation from the Hon. Paul Martin in New York was read. Following this the guests had tea in the dining-room and then were conducted over the building in groups by some of the students.

On Sunday, the building was open for inspection by the public, who flocked there in very large numbers. The building has three floors. On the ground floor are the demonstration room, two lecture rooms, two laboratories, the dining-room, kitchen, recreation room, and storerooms. The first floor has the library, reception room, and offices, as well as some living quarters for students and staff. The second floor is entirely student living



The library

quarters, including two sitting-rooms with kitchenettes and two small laundries.

The Windsor taxpayers seemed tremendously interested and pleased with what they saw; as well they might be, for the erection of this building demonstrates that they are progressive and open to new ideas and is a splendid community effort.

NETTIE D. FIDLER

Director

Metropolitan School of Nursing

Institutional Nursing

The Patient on a Bradford Frame

MARY E. PICKENS

Average reading time — 4 min. 48 sec.

THE BRADFORD frame has been used for a wide variety of orthopedic conditions so that it is probable every nurse has cared for patients on this piece of equipment. In the minds of many lay people, being subjected to a period of treatment on such a frame is practically synonymous with being strung up on the torture-rack of ancient history. Since the Bradford frame enables the nurse to care for her patient with a minimum of discomfort to him, it is well that she should understand the patient's point of view and be ready to meet it satisfactorily. Moreover, there are some special points in nursing care that should be thoroughly familiar to every nurse. These will be discussed in detail.

PSYCHOLOGICAL APPROACH

Typically, the patient who is to be placed on a Bradford frame can be sure that he is due for a fairly long period of hospitalization. The first necessity, then, is to assist him to adjust to the status of patient and still maintain a normal outlook on life. This becomes easier if he understands what is going to happen. The nurse should take the time to explain the treatment before she starts to put the patient into position. This precaution is equally important with the relatives who are so fearful of the fate of their loved one.

Other ways in which the patient will be helped to adjust more quickly to his new situation include: placing his bed near a window; arranging the

lights to afford the maximum of illumination and the minimum of glare; putting him in a room with cheerful companions; moving the bed out to the sunroom whenever possible; providing him with some form of occupational therapy suitable to his capacity and position. With most older patients there is the problem of how bills are going to be paid during the period of enforced idleness. If some useful hobby can be started that will be of commercial value in the future the patient will be more co-operative in submitting to the necessary care. Provision should be made for the continued education of school-aged children that they may not suffer the loss of their term's work.

PHYSICAL FACTORS

The nurse should understand the purpose of the apparatus, why it is being used, and what it is hoped will be accomplished. She should know how the set-up should look and check the apparatus regularly to prevent contortions. Whenever possible the patient should be encouraged to help himself, after the second or third day, to prevent muscular weakness. There is no more practical way to give the patient a feeling of independence.

Good nursing care will follow when the nurse knows the various positions that afford the patient comfort. She should have a knowledge of the limitations when moving her patient. She should know how to turn him over, carefully supporting both the shoulder and pelvic girdles. Obviously, this should not be attempted by a nurse working alone. Extreme care and gentleness are essential to avoid

Miss Pickens is nursing arts instructor at the Peterborough Civic Hospital, Ont.

motion of the spine which would be accompanied by excruciating pain. It is a safe rule to follow that too much help at this time is better than too little.

Foot-drop can be an alarming complication if proper precautions are not taken. Support and exercises for the feet should be the concern of both nurse and patient. A properly adjusted foot-board is a simple remedy that can be used at the foot of the bed to support the feet and at the same time elevate the bed-clothes to eliminate the drag of their weight. Active or passive exercises may be ordered, in addition.

The diet of a patient on a Bradford frame should be adequate in calories with plenty of fluid and roughage. Usually it is high in calcium, phosphorus, vitamins A and D. The patient should be encouraged to feed himself from a table suspended over the frame. The food should be prepared in advance to facilitate easy handling—meat cut, salad shredded, etc.

The primary purpose of good personal hygiene is, of course, to promote the comfort of the patient. Equally important is the prevention of decubitus ulcers. Thus, a daily bath and adequate alcohol rubs will help to care for the skin. Properly made pads to eliminate points of pressure will increase the patient's ease and avoid undue friction on the skin.

Elimination should be regulated by diet where possible. Harsh cathartics should be avoided. When ordered by the physician, a small enema may be given. An accurate record of fluid intake and output should be kept.

The nurse should keep a close watch for a possible distended bladder. Incontinence of urine should be controlled by the use of a retention catheter or by tidal irrigation.

The frame should be elevated on bases and be arranged with a divided cover so that the spine is not disturbed when the patient uses a bed-pan. Different orthopedic conditions present varied problems but the nurse should know how to place the bed-pan in position with the minimum of discomfort to the patient and the maximum of protection to the canvas on the frame and the patient. Sometimes a trapeze is provided with which the patient can help himself on the pan if the frame is not sufficiently elevated.

TRACTION —

The application or removal of traction is the doctor's responsibility and it is only upon his direct order and explicit instructions that the nurse either applies it or makes any alteration in it once it has been applied. A special traction tray or basket, completely stocked with orthopedic requirements, simplifies the application of traction.

If traction is being used for the treatment of the patient on a Bradford frame, it is the nurse's responsibility to check it several times daily to be sure the ropes are in the pulley sockets and the weights are free. The bed-clothes should not be allowed to interfere with the ropes at any time. It is important to observe the patient during the time he is asleep to ensure that the desired posture is maintained.

The Common Cold

It is believed that the constriction of the small blood vessels supplying the nasal mucous membranes and the resultant blanching makes these membranes more susceptible to invasion of pathogenic organisms because the source of white cells and antibodies is diminished. . . . That there is a psychosomatic aspect to the development of colds is shown by

the fact that exposure to cold of individuals under anxiety or emotional tension causes the blanching of the vessels to be prolonged and, therefore, they are susceptible for a longer period. In a study of a group of kindergarten children it was revealed that children of divorced parents contracted on the average a greater number of colds than did others.

The Stryker Frame

ETHEL J. FENWICK

Average reading time — 4 min. 6 sec.

THE STRYKER frame is a modified form of the well-known Bradford frame, which fits on a stand having a pivot device at each end. It was designed by Dr. Stryker of the University of Michigan Hospital orthopedic staff. The first Stryker frame was made in 1937-38. Dr. Stryker's purpose in designing this equipment was to provide a set of orthopedic frames on which the patient could be turned with ease by one nurse.

The indications for its use are:

- (1) Spinal injuries with paralysis.
- (2) Spinal operations requiring post-ural correction.

The complete Stryker frame includes posterior and anterior pieces, standard, frame cart, head-piece, arm supports, foot supports, overhead frame, and tray platform.

Both the anterior and posterior frames have an upper and lower canvas cover for support. The canvas covers are usually strapped in place with buckle straps to keep the canvas constantly taut. When buckles are used they must be placed with the buckles off centre to prevent pressure from them with any sagging of the covers. The upper anterior canvas should extend from just below the shoulder girdle to the symphysis pubis while the upper posterior frame will cover from the symphysis pubis to the top of the frame. The lower canvas cover on each frame should extend from 4" below the pubic bone to the internal malleolus. The 4" space mentioned is to provide for a perineal opening. After the nurse has checked the placement of the canvas and tightened the buckles she is then ready to pad and cover it.

PADDING

The padding used on Stryker frames

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varies with different hospitals. The padding may be cellucotton covered with gauze. These are made to fit each frame and then taped in place. Some hospitals fold a blanket above the canvas, covered with a sheet. Others use a blanket between the canvas and the straps and a proper sponge rubber mattress above the canvas. Whichever technique is used, a sheet covers the padding and passes over the edge of the frame and is pinned just under the edge of the metal frame. If separate upper and lower covers are used the perineal opening is left free on the anterior frame, and a 4" or 6" wide padded buttock strap is used for the posterior frame. A split anterior cover is most satisfactory for female patients. The buttock strap should be kept in place except when the bed-pan is being used, otherwise there will be sagging of the buttocks and poor spinal alignment.

When a set of Stryker frames is covered the nurse must be careful to see that the perineal openings on the anterior and posterior frames match exactly. Otherwise the patient will have to be moved up or down on the frame and the aim of the nursing care defeated.

The most satisfactory type of head-piece is one attached to the anterior frame. It consists of a piece of canvas with a heavy wire large enough to go around the head to give the canvas support. The canvas has an opening in the centre large enough to surround the patient's eyes, nose, and mouth. A quilted face-piece, with similar sized openings in the centre, fits inside the canvas and is much softer and more comfortable for the patient and can be changed for laundering.

The feet are supported in a normal position by a canvas covered foot support, with the heels free. This is removable.

A bar, running longitudinally above the patient, may be useful to him in lifting his shoulders if this is allowed.

Two wooden arm-boards fit into sockets in the runners below the frame. These, covered with pillows, support his arms when on either frame—they are not used extensively when the patient is on the anterior frame. Runners or standard are the non-movable part of the frame. The frame cart suspends the frame and makes it easy to move it.

The tray platform is a sliding board approximately four feet in length, which fits into the runners and is used for meal trays, letter writing, and other occupations when the patient is on the anterior frame.

TO TURN THE PATIENT

Remove the bed clothing; place a pillow over the legs lengthwise; remove the arm-boards, foot-board, and head pillow; place the anterior frame with the narrow end toward head of patient, the face support over the face; press the ends down over bolts and hold by tightening the wing nuts, squeezing the patient snugly between the frames.

The patient is told to wrap his arms around the anterior frame. If he is very thin or small, strap him in. The nurse may strap the patient to the lower frame and put on the upper frame. The alternative method is to put on upper frame and strap the two together. Release the stop locks at each end.

Instruct the patient as to which way you are going to turn the frame. Turn the frame quickly being careful not to jar the patient. Make sure the spring locks have snapped back into place before letting go of the frame. The posterior frame can now be removed. The foot-board and arm-board may be replaced and the bed remade.

In the prone position the patient is able to read, write, feed himself, and do occupational therapy. Intravenous and transfusion treatments may be given in either position.

The Stryker frame enables one nurse to turn the patient easily and safely. The use of this frame has saved much nursing time, has frequently eliminated the use of plaster casts, and saved the patient from much discomfort and inconvenience.

Bile Acids

The chief functions of bile are these:

1. Bile acids aid in the emulsification and absorption of fats and increase the effectiveness of the pancreatic fat-splitting enzyme lipase. They also serve to lower the surface tension of fats so that they lend themselves more readily to emulsification. Although pancreatic lipase is active in the absence of bile acids, its activity is increased approximately threefold in the presence of bile.

2. Bile acids promote the formation of bile by the liver. After aiding in digestion, 80 to 90 per cent of the bile acids are absorbed into the portal circulation and carried to the liver, where they lend themselves to resynthesis of bile by the liver.

3. Bile acids aid in the absorption of iron and calcium and are necessary to the absorption of vitamins D, E and K and of carotene,

the precursor of vitamin A.

4. Bile acids aid in maintenance of normal intestinal motility. While bile acids are not primarily cathartics or laxatives, they do have an important role in the maintenance of normal peristalsis.

5. Bile acids are anti-putrefactive and inhibit excessive growth of *Escherichia coli*, but they are not to be considered as general intestinal antiseptics.

6. Bile acids prevent the precipitation of cholesterol and fatty acids in the gallbladder by holding fat acids in solution. This does not mean that bile acids will "dissolve" gallstones in the gallbladder, nor does it necessarily mean that a person with a low bile output is more susceptible to gallstone formation.

—*Journal of the American Medical Association*

Private Duty Nursing

Integration of Hospital and Community Services

SOPHIE HOLMES

Average reading time — 7 min. 12 sec.

NURSING HAS BEEN DEFINED as "a basic concept for the promotion of health, the prevention of disease, and the care and rehabilitation of the sick." The very essence of that definition illustrates the need for an understanding and complete co-ordination of the various branches of nursing. In the prevention of disease, the public health nurse, the industrial nurse, and social agencies all work together. But, since disease does attack in spite of our fight against it, the curing, or at least the easing of suffering and distress, is our aim, whether it be in the hospital or in the home. And here again the best service is given where there is complete co-operation and accord among the nursing services brought in, an intelligent conception of each person's work, and a very real respect for what each one is trying to do.

The most efficient, helpful, and time-saving centre from which these services can be drawn is through a community service agency. This is a central registry of the various branches of organized help in a community, which may be called upon for the health needs of that region. It is invaluable to those cities, towns, or districts that operate one, since it saves overlapping of services and creates a more direct means of caring for the residents. It is very important to consider the hospital as a member of such an agency and not a unit apart, for the best care cannot be given unless all these branches are cor-

related. The person in the home is that same person who is now the patient in the hospital, and his background with all its problems and human relationships has a great bearing on his recovery. It is being realized more and more that the psychological disturbances of the patient have far-reaching effects on his specific disease and only by knowing the whole story can helpful and wise treatment be given.

WORKING TOGETHER

I should like to take you to a mythical community and give you a picture of how the various branches of nursing work together, each one necessary and responsible in its contributions to the welfare of the patient.

The public health nurse has learned at the school that the doctor had to come during the night to see Betty Smith's father—it was his heart again. So the first call on her rounds is at the Smith's. Already arrangements have been made for his admission to the hospital and she reads in Mr. Smith's face his anxiety over his condition and what his inability to provide for his family now, and perhaps ever, means. She also reads apprehension of what the hospital will be like and what he will have to do. Here she is able to do one of her most helpful pieces of work for she has kept in touch with the current trends of treatment and hospital procedures. She is able to describe his setting there, whom he is likely to meet, and what his general treatment will be. She will tell him and his family the

Miss Holmes is a private duty nurse in Toronto.

regulations about visiting and even what articles he will find useful to take with him. This attitude of assurance, and knowing whereof she speaks, inspires confidence in the patient and has a very real therapeutic value.

Now another branch of community service is called upon. Since there is no one to leave with the youngest little girl, Mrs. Smith cannot accompany her husband to the hospital. The Red Cross transportation service of our mythical town has said they would be very glad to take him. They call for him with a comfortable car.

When the preliminaries of admission are completed, the patient is taken to the ward. The head nurse, or the nurse assigned to look after Mr. Smith, takes him to his bed and, in her intuitive understanding of his apprehension, assures him of her interest in his care.

In the meantime, the public health nurse has called the head nurse to tell her something of his situation at home. This information, necessary to her and to the doctors in assessing Mr. Smith's case, the head nurse will pass on to the social service worker or public health nurse on the hospital staff. Realizing his anxiety over financial matters, the staff social worker will get in touch with Mr. Smith's employer so that his sick benefit insurance can be paid as soon as it is due—a factor in his treatment as important as any medicine he might take.

On further examination of the patient, the doctor feels that the seriousness of his condition warrants the calling of a private duty nurse. The day period of duty seemed to give the greatest opportunities for service.

When the selected nurse comes on duty, the head nurse gives her any special information about Mr. Smith that she feels will help her in her care of him. She will see that the new nurse is oriented in her surroundings to give her assurance and confidence in herself and her ability to carry out her duties. Her intimate contact with the patient and his family is a valuable help in his recovery and an inter-

pretive link with the hospital background.

The relationship between the head nurse and the private duty nurse is again part of that correlation so necessary to good nursing care—the private duty nurse in her interpretation of the institutional side to the patient and of the patient to the head nurse; the head nurse in her confidence and reliance in the bedside care given by the private nurse. The head nurse has the satisfaction of many contacts to complete her work picture; the private duty nurse the satisfaction of seeing health restored by her direct care.

At four o'clock, the ward nurse assumes Mr. Smith's care when the private duty nurse goes off duty. He will, of course, have only a share of her time, divided as it is among the patients assigned to her. In her contacts and care of her patients, the ward nurse learns one of the great lessons in psychology and human relationships, if she perceives them always as individuals and not just as number such-and-such on the treatment card. If Mr. Jones is cross with her, it is probably some worry his wife brought him from home. She gives an extra word of cheer to Mr. Brown because he dreads the long sleepless nights.

A clinic, with our cardiac patient as the subject, should include, besides the doctors, health teacher, head nurse, and the nurses giving bedside care, a dietitian and occupational therapist. The dietitian can supervise and plan his diet more intelligently if she knows his likes and dislikes and realizes by the condition in which she sees him, and as she hears his case discussed, what he is permitted to eat and would enjoy. Some hospitals have a space on the card for patients' food likes and dislikes. This is kept in the ward kitchen and referred to when meals are being served. It seems an excellent idea.

The occupational therapist has a great contribution to make in the physical and mental health of patients who may need some outlet for a life with new restrictions and

enforced leisure. The patient may find he possesses a variety of unsuspected skills, which in their use give him satisfaction, peace of mind, and even new ways of earning when he returns home.

Through the close integration of all these branches of service, our patient has recovered sufficiently to go home. The private duty nurse has been with him during his stay in hospital and will see him established in his home once more. Through her active interest in public health matters, she has been able to give him and his family much useful information for their daily life, all in the course of her contact during his illness. By now she knows the lay-out of their home and can suggest arrangements to save the patient's energy and the family.

Again we have the close relationship of services on his discharge. Of course, he will see a familiar face when he returns to clinic—his friend, the hospital social worker. And so, with these arrangements completed and his clinic card dated for his check-up visit, our Red Cross workers again call to drive him home. The hospital social worker has already called the

district public health nurse to say that he is going home and to tell her of his general condition on discharge.

Arrangements have been made for the Victorian Order nurse to come in and give him a daily bath and to see that all is well at the Smith's. She will, of course, be given the background of her case and the orders and routine to be carried out by the patient. She, too, has kept abreast of hospital procedures and, by her familiarity with all they tell her and ask her, forges another link in our chain of health service.

Still another community service will contribute to Mr. Smith's welfare when he returns to his work. The industrial nurse at his plant has watched Mr. Smith since his previous lighter attack and, of course, has kept in touch with the hospital public health worker during his stay there. On his return to the plant, she will keep a careful check on him to see that he is not overdoing things. Thus she makes her contribution, by her care and vigilance recognizing Mr. Smith's privilege and right to take his place again among his fellow workers.

WHO Recruiting Nurses

Joint WHO/UNICEF programs are developing in the Far East and WHO nursing programs in other regions are being planned. A limited number of well-qualified, experienced nurses will be needed for the following types of work:

1. As members of field demonstration teams to work on special projects with national and local health administrations.

2. To advise and to participate in training programs for nurses, midwives, and auxiliary nursing personnel.

3. To strengthen existing public health nursing services and to assist in improving standards of nursing care and the clinical experience of student nurses in hospital.

In addition, a limited number of positions are anticipated for regional nursing advisers as well as for short-term consultants in public health and other aspects of nursing.

Applications are invited from the following:

- A. *Public health nurses* who have had experience in one or more of the following:

1. Polyvalent (generalized) public health nursing services.

2. A specialized field such as maternal and child health, tuberculosis, venereal disease, tropical diseases.

3. Administration and/or teaching in schools of nursing, including public health nursing.

- B. *Public health nurses with midwifery* who have had experience in one or more of the following:

1. Polyvalent public health nursing services.

2. Midwifery, hospital, and/or domiciliary.

3. The teaching of midwives.

- C. *Nurses with preparation and experience in pediatric and in tuberculosis nursing.*

For further information regarding requirements, duties, salaries, allowances, etc., write to the **Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.**, or directly to the **Office of Personnel, World Health Organization, Geneva, Switzerland.**

Public Health Nursing

Family Service in a Generalized Health Agency

MARJORIE WILLIS, B.A.Sc.

Average reading time — 15 min. 12 sec.

A GROUP OF SUPERVISORS from generalized public health agencies met in eastern Canada recently. After discussing the scope of a generalized service, they agreed that although public health nurses readily accept the concept of a family service in theory, they do not always put these theories into practice. This complaint is not a new one. In a study made in the United States in 1937, in which the records of three rural public health nurses were analyzed to ascertain the extent to which the principle of "the family as a unit" was observed in giving health service, the following conclusion was reached:

Little or no evidence could be found that the nurses were rendering a complete family service . . . Even when all the services rendered to a family during the period of a year were included, less than one-half of the individuals were given attention. Evidently, from the data assembled, the nurses did not render a diversified service when they made a home call . . . !

This conclusion was prefaced by the remark that it was necessarily qualified in terms of the faithfulness of the nurses in recording all services.

I propose to give a brief description of our agency which has a generalized health program. This, with some consideration of the community resources at our disposal, will indicate that we *do* give a family health service.

When I entered my school of nursing to begin training one of the first precepts I learned—which I soon

found was to be a major theme throughout the three-year course—was that we must not think of "the appendix" in bed three and "the leg" in bed four. We must think of Mr. Smith who had to have an appendectomy and Mr. Jones who broke his leg last night. Occasionally one would hear a nurse say she was "going to do up the appendix in three" but not very often, and not nurses from our era. We were pretty thoroughly indoctrinated from the beginning with the idea that the *patient* was an *individual*, with his own individual likes and dislikes, pains and worries, responsibilities and joys. His relationship to the ward was of minor importance, since his stay in this environment was usually limited. Naturally we had some contacts with the patient's family and visitors, and we probably became fairly adept at dealing with them; but we were taught to remember that we were *in* our environment and they were *out* of theirs.

In our senior year, when we were beginning to feel fairly sure of ourselves, we were introduced to the community through such media as hospital social service, O.P.D., V.O.N., T.B. control, and the city health service. The contact was brief and we hurried back to the security of our hospital with a maze of interesting and sometimes startling impressions. The understanding we subsequently showed of our patients' relationship to the community varied in quality and in endurance. The important thing is that this brief field experience was a major part of our introduction to preventive medicine—the part

Miss Willis is a staff nurse with the Metropolitan Health Committee in Vancouver.

most responsible for leading us on to specialize in public health nursing.

When we entered university the theme changed. Now, it was *the family*. Very early in our course we studied sociology in terms of this—the basic unit of society—and everything else we learned we adapted to it and its members, and to collections of it, the community.

A question now is posed. Are we, in the rush and pressure of our duties—our everyday routines and special periodic activities plus the startling out-of-the-way events which bring excitement to our work and revision to our work-plans—are we applying our knowledge to the basic unit of society? Are we public health nurses in a generalized program really giving a family service?

HEALTH UNITS

To evaluate a service, one should first have some idea of the background for it—the agency through which the service is rendered. Our agency is called the Metropolitan Health Committee of Greater Vancouver. It is the official health agency and serves an area of approximately 248 square miles, with a population of nearly 500,000. This area is divided into six units, each administered by a medical director and nursing supervisor and staffed with public health nurses, sanitary inspectors, and clerks. Coordinating the nurses' work is the director of nurses in the central office. Here, also, are the consultants and specialized workers: the educational director, mental hygienists, audiometerists, senior school medical officer, dentists, nutritionists, and quarantine officers. Integrating all these components into a smooth-functioning health department is the medical health officer.

For functional purposes, each unit is divided into districts. In each district there is a public health nurse who serves about 7,000 of the population. Her area corresponds to the school district but do not suppose that her work is similarly limited. Categorically, it has three main divisions—child welfare, school health,

and communicable disease control—with the mental hygiene program an integral part of all three.

CHILD HEALTH CENTRES

The focal point of the child welfare work lies in the Child Health Centre. These centres are open every one, two, or four weeks, depending on the needs of the area served, and are located so that there is one within reasonable walking distance in each community. One of the routine ways in which new mothers learn about the clinic is through the use of the "Birth Lists." These lists, compiled monthly from data from the Division of Vital Statistics, give the names and addresses of all the babies born in each district. The public health nurse visits, interprets the service, and, if they wish to attend, arranges appointments for them to the nearest child health centre when the babies are six weeks old. She advises the mother concerning any problems that need immediate attention (such things as feeding problems won't wait for clinic day!). She may refer the family to the V.O.N. for a demonstration bath or weighing. On this same visit the nurse will note the mother's appearance and perhaps offer advice about her own health as may be indicated (nutrition, rest, etc.) or she may help her plan her daily schedule to accommodate the new member of the family. Unless it is a "first baby," one of the interesting parts of these visits is consideration of the pre-school children. How do they feel toward the new arrival? Were they prepared for it? Is the mother alert to the need for distributing her attention so that none will lose out on the all-important need for mothering? And, of course, what is their general physical appearance? The answers that the public health nurse gives to these questions determine her future relationship to this family. She may feel that attendance at the child health centre, with appointments later for the pre-schools' "booster" immunizations, will meet the needs; or she may mark them for periodic home supervision.

Other mothers come to child health centres because of the favorable reports they have heard from mothers already attending. One of the important means of bringing mothers to child health centres is to publicize this service in the other phases of our work. By being alert to such opportunities, the public health nurse can bring this service to the newcomers whose babies were born elsewhere, and to prenatal patients (with referral to the V.O.N. for prenatal supervision and mothercraft classes) whom she often meets in the course of her generalized health program.

Mothers may bring their babies to our child health centres until they are two years old, reporting at the intervals decided on by the public health nurse. Our tangible services include weighing, supervision of feeding and early training, and the immunizations. Our more intangible services include encouragement, "moral support," and the fostering of self-confidence and skill in the mother. Our rewards? The transformation of a harassed and frightened woman, with a wailing infant, to a beaming mother with a healthy rosy child. The competence and self-confidence of the women literally grows before our eyes. There is a gradually decreasing infant mortality rate which may be attributed a little, at least, to these child health centres. They play an important role in the family health service.

THE PRESCHOOL CHILD

The child from two to six interests the public health nurse too. After he graduates from the child health centre he is not entirely lost to her until he shows up at school! If a mother appears to need health teaching, in addition to that given at the centre, the public health nurse will continue with home supervision. Also the nurse will observe preschool children in the course of other home visits, concerning school children, or when making communicable disease visits such as tuberculosis or venereal disease. Then, almost before she knows it, she will meet her ex-child health

centre babies at one of the district's kindergartens or play schools where she gives health supervision.

This two-to-six period is so vital in the development of attitudes and the establishment of behavior patterns. Here, opportunities present themselves for spotting maternal oversolicitousness, excessive criticism and restraint, and anxiety. Mental hygiene principles can be introduced in conferences with the mothers, pointing out the meaning of the child's behavior. As the mothers' understanding grows, so will their ability to foster the growth of wholesome, well-rounded personalities in their children. Since study groups, to which the public health nurse may be able to come periodically, afford preschool mothers much instruction and moral support, we are quick to advocate these and help with them as requested. We remember the preschool group in our talks to the Parent-Teacher Association, mothers' groups, or service clubs too, ever alert to give them the important place they merit in the family picture.

THE SCHOOL CHILD

Now let us welcome these healthy, well-adjusted products of our child welfare program at school! Here we spend about 50 per cent of our time and again we find many opportunities for visiting the homes and getting to know and help our families. Our primary function in school is to promote health by incorporating positive health teaching in all the activities that come within the scope of the nurse. We don't have to be a public health nurse to render simple first aid, or test vision, but we do to recognize the teaching opportunities afforded, and to present our health teaching in a way that will be meaningful to the particular age-group concerned.

Throughout all the procedures that the public health nurse carries out to evaluate the status of the children and foster a still higher health standard, she will be alert to their mental health. Mental hygiene principles will be included in her dealings with

children, teachers, and parents and, where indicated, the special services of a mental hygienist will be enlisted. In these cases the public health nurse prepares the social history and arranges for all interested workers to be present at the conference. Besides giving help to the child and family concerned, such conferences are of educational value to the teachers, social workers, and public health nurses attending.

"Selling" preventive medicine and the importance of early diagnosis and treatment: these rank high in the objectives of a public health nurse in a general service. They are kept well in mind in the school program. The nurse knows that some of her health teaching, if effectively done, will be carried over to the home by the children themselves. The basic principles of preventive medicine, effectively interpreted throughout their school life will lead, we hope, to the practice of having an annual physical examination, which they will assume responsibility for obtaining.

COMMUNICABLE DISEASE CONTROL

Here, the public health nurse works closely with other agencies, notably the Divisions of Tuberculosis and Venereal Disease Control and the Quarantine Department. Tuberculosis control is probably the biggest part of this program, the public health nurse doing most of the field work for the Division, which is a provincial department. This includes the supervision of patients "on the cure" at home and the follow-up of contacts. While there are some cut-and-dried precepts for one to follow in this work, each patient is a case unto himself, and to do this work effectively calls for a fair amount of case work. There are real challenges to the public health nurse here—the old tuberculosis patient, who has fixed ideas which may need to be modified, or who is depressed and discouraged, or bored and tempted to over-do; the new one who has little understanding of the disease, who is shocked at his diagnosis and sudden loss of independence for himself and

his family, and is faced with the stupendous task of adjusting to a completely new way of living. Yes, indeed! each patient is different, each family presents a new and interesting picture. Without a family service, a tuberculosis service would be relatively valueless, so great a bearing does the essential mental rest have on the cure of the disease.

REFERRING FOR HELP

Growth in one's ability to give a family service implies increased skill in the use of community resources—social agencies for financial aid or therapeutic case work, the children's clinic for diagnosis and treatment, social service for referral of special problems of patients, etc. Most of these agencies and our collaboration with them are fairly well known. As we grow familiar with our district, their names become associated with names of individual workers, and our knowledge of their different scopes becomes clearer. All the people we want to help won't fall into these categories, though we are surprised to realize that community resources apply to such everyday things as the Sunday school we took for granted when we were younger. We get to know which Cub packs have the shortest waiting lists (meanwhile bemoaning the lack of youth leaders) and we are thankful if we have a Neighborhood House near enough for our families to use. We refer families to the Campers' Association in summer and the Christmas Cheer Committee in winter. We rejoice at having an Occupational Therapy Department in our agency for our patients.

PROBLEMS, TOO!

One of the pleasant things about our work is the trust and warmth with which we are usually received into the homes. Most parents realize that we have come because we are genuinely interested in their family's welfare and, while some act sooner on our advice, some later, most of them welcome us and talk with us. Some, however, for various reasons, do not want to be "bothered with the nurses"

and their reception is anything but cordial. By repeated, friendly, and, apparently, casual visits, often the most recalcitrant parent can be won over, and some precepts of health imbued in her without her knowing it. Such cases can be hard and discouraging but the least sign of modified behavior buoys us up and makes the effort seem worthwhile. Small gains here equal big gains in a better family.

I have found that it can be harder to teach a mother the importance of a balanced life than the importance of a balanced diet. A family that needs to be taught this so often is a family subsisting on a small income and all its concomitants. In such a home lack of money, lack of knowledge, and lack of ability to budget and plan meals are just some of the more obvious problems. More difficult is the lack of *joie de vivre*—the lack of ability to make some fun in the family. Even more subtle is the mother's feeling of inadequacy due, perhaps, to her own unresolved childhood difficulties, her lack of education, or clothes, or overwork, that makes her shun social intercourse and keep close to her kitchen. Then we get the hopeless irritable parents who create unstable, negative environments, and children steeped in a bath of adult apathy. To be effective, a mental hygiene program must be an integral part of every branch of a family service.

Health and happiness go together. A good public health program is a health and welfare program. A public health nurse, at all worthy of her job in this great work, realizes this.

HUMAN RELATIONS

There are many variables in the performance of a family service. It is generally agreed that human relations are complicated, but human relations in the life of a public health nurse can be about as staggering as any! The staff nurse is the liaison between more different people and organizations than anyone else in the health and welfare set-up. Whereas the contacts of supervisors, doctors,

consultants, or specialists with the other people are, of necessity, intermittent and comparatively brief, the nurses' contact is a close, day-to-day affair. School — pupil — parents — nurse; school board — health department — principal — nurse; T.B. patient — patient's family — T.B. medical — T.B. social service — nurse; child health centre — patient — health department — pediatrician — nurse! The number of combinations possible in all these relationships is infinite. She is a newcomer in a school where many of the teachers have been since before she was born. Every home the public health nurse goes into is a new environment. Here it is the patient who is in his environment and the nurse who is out of hers. She must adapt herself and her knowledge of health, her teaching, and interviewing to every home, as to a new job.

The way things have gone in school during the morning will affect the way things go in the district or clinic in the afternoon. If a nurse goes into a home to tell the mother about a child's diseased tonsils and deals only with that, apparently failing to consider that the mother is thin and listless with her housework only half done by mid-afternoon, that the preschool child is barefooted on the cold floor, with pale cheeks and runny nose, and that the dirty dishes in the sink indicate a lunch of greasy pancakes and little else, it is likely because the pressure of other problems in her work at that particular time precludes a more complete service on this visit. A public health nurse cannot help but become more skilled at interpreting such pictures and helping to improve them. To make the best use of her time, she is bound to consider more than the specific health problem which brought her into the home. Just as important, she is bound to consider carefully the laws of learning in her health teaching if she is to teach at all and she is bound to steer a gradual course toward her ultimate goal of fostering independence, the recognition of health and welfare problems by the family, and the assumption of responsibility for them.

We public health nurses are doing these things. Where we may be falling down is in the recording of them. We are accused of using the "not enough time" excuse too much but most nurses will agree that it is a pertinent factor. With so many dynamic and challenging situations in our districts, maybe it is a human enough mistake to place more importance on getting out and trying to do something about them than on leaving a record of our

efforts for other nurses to build on.

How to strike a balance, with efficiency and despatch, between service rendered and service recorded—that is a task facing the staff public health nurse in a generalized agency. Only then will her family service be demonstrable and continuity of that service be assured. Then will long-term planning be encouraged with the opportunity for evaluating the effectiveness of her health teaching.

Five Sisters

Something of a record appears to be held by the Lettner family of Nokomis, Sask. Five sisters have completed their training as nurses, four of them being graduates of the Grey Nuns' Hospital in Regina. Can any other Canadian family exceed this record? We would be interested to receive the particulars and, if possible, a photograph.

Four of the sisters are still in active nursing. Reading from left to right we find: **Corinne**, who graduated from the General Hospital, Sault Ste. Marie, in 1935. She went overseas with No. 8 C.G.H., R.C.A.M.C., and served in England, Sicily,

and Italy. At present she is in the anesthetic department of the Regina General Hospital. **Blanche** was the first to graduate from the Regina Grey Nuns' Hospital in 1938. She has served as matron in rural hospitals in Saskatchewan and is presently in charge of x-ray and laboratory at the hospital at High River, Alta. **Lillian** graduated in 1942 and is now an embalmer in a Regina funeral home. **Leonore** finished her training in 1944. After engaging in staff nursing in Saskatchewan rural hospitals, she was married. **Phyllis** graduated in 1949 and is at present on the staff of home-town Union Hospital.



Aux Infirmières Canadiennes—Françaises

Mademoiselle Radio 1950

SUZANNE GIROUX

Lecture — 5 min. 36 sec.

CE SERA VOUS—la Mademoiselle Radio 1950—si vous voulez bien suivre mon conseil. Ecoutez la radio tous les lundis soir à 8:30 p.m. et tous les mardis à 8:00 p.m. Je m'adresse à vous qui vous vous proposez de venir au congrès de l'Association des Infirmières du Canada à Vancouver (26-30 juin).

Comment vous préparez à ce congrès? Comment retirer le plus de bénéfice possible des Foyers d'Etudes préparés sur les sujets de la plus grande actualité, en connaissant la technique qui sera employée et ensuite en l'applicant aux sujets à l'étude.

Deux programmes de radio à notre connaissance vous donneront une bonne idée de la technique employée dans les Foyers d'Etude: *Le Choc des Idées*—le lundi à 8:30 p.m. *Les Idées en Marches*—le mardi à 8:00 p.m. Ecoutez-bien! Le sujet traité dans notre cas est secondaire, quoique toujours très intéressant, mais que votre attention se porte sur la technique, la manière de faire. Votre esprit alors sera prêt pour le congrès. Il ne vous restera plus qu'à préparer vos toilettes et faire vos valises.

Où auront lieu ces Foyers d'Etudes? L'Université de la Colombie-Britannique est à notre disposition. L'atmosphère scholastique, le campus, qui est ici un beau tapis de verdure, présentent des conditions favorables à l'étude et à la réflexion.

Qu'entend-on par Foyer d'Etude? Dans un Foyer, dans une famille, chacun donne son idée. Les parents,

personnes expérimentées, dirigent la discussion. Les réflexions des enfants ont une influence sur les parents et celles des parents sur la conduite des enfants. Cette influence se fera sentir plus tard à leur travail envers leurs compagnes, etc.

Vous comprenez maintenant pourquoi l'on a donné ce nom de Foyer d'Etude aux conférences qui auront lieu au congrès.

Chacune aura le privilège de donner son idée sur le sujet traité. Toutes les idées exprimées, les réflexions faites, les suggestions apportées seront réunies; nous reviendrons plus riches, ayant bénéficié de l'expérience des réflexions des unes et des autres.

Quelle est la technique employée? Voici comment l'on procède. Une personne est chargée de diriger le Foyer d'Etude. Son rôle est de se taire le plus souvent possible mais elle doit voir à ce que tout marche bien. Une question, un problème est exposé, question importante qui retiendra l'attention des membres du Foyer mais qui tout de même est à la portée de tous. Des spécialistes en la matière sont invités; ils sont chargés d'exposer les faits.

Les membres de la conférence se divisent par groupe de 12 à 18 (véritable Foyer Canadien-français!). Chaque Foyer a une *convocatrice*, une personne capable d'animer une discussion; une *observatrice* dont le rôle est de juger de la valeur de la discussion; une *secrétaire* qui fera rapport des activités de son petit groupe.

Comment assurer le succès d'un Foyer d'Etude? La réponse est simple: en s'y préparant.

(1) Le programme est préparé avec

Mlle Giroux est en charge des Foyers d'Etudes pour les infirmières françaises au congrès de l'A.I.C. en juin.

soin par les personnes devant y prendre part. (2) Les membres, assistant au Foyer d'Etudes, doivent venir préparés à y prendre une part active. (3) Des assistantes doivent être préparées afin d'assurer plus grand rendement possible. (4) Quelques-unes de ces assistantes doivent être préparées avant le congrès. (5) Il faut s'arrêter et examiner le travail accompli. (6) La discussion se fait par petit groupe. Les rapports de chacun des groupes sont communiqués à l'assemblée générale (réunion de tous les petits groupes étudiant le même sujet). (7) Le communiqué de ces rapports a pour but de faire connaître les divers points de vue. (8) Cela permet également, en comparant les rapports de chaque groupe, de juger de la valeur de la discussion de notre petit groupe. (9) L'observatrice, qui elle aussi fait son rapport, nous présente, en quelque sorte, un miroir, un tableau de notre discussion, libre à nous de retrancher, d'ajouter. (10) Le groupe s'engage à répandre, à propager les décisions prises lors de la conférence.

FOYER D'ETUDE EN FRANÇAIS

Pour la première fois l'A.I.C., lors d'un congrès biennal, organise des séances en français. Nous invitons toutes les infirmières de langue fran-

çaise à y prendre part, particulièrement nos campagnes des provinces maritimes, de l'Ontario, du Manitoba, et toutes les autres qui voudront se joindre à nous, et naturellement celles du Québec.

Le sujet discuté—Le travail d'équipe en nursing: Jadis, il n'y avait que le médecin et l'infirmière auprès du malade. Auprès du bien portant, il n'y avait personne pour le conseiller sur les moyens à prendre pour conserver sa bonne santé. Aujourd'hui, le médecin et l'infirmière sont toujours au chevet du malade mais en plus l'on rencontre la diététiste, l'auxiliaire sociale, l'aide, etc., travaillant tous ensemble au rétablissement du malade.

En hygiène publique l'on rencontre le médecin et l'infirmière, mais non dans un rôle de soignante mais d'éducatrice. Elle aussi fait appel à la diététiste, à la travailleuse sociale, à l'aide entraînée pour donner des soins à domicile, etc.

Notre société a-t-elle besoin de toutes ces personnes? Quel est le rôle de chacune? Vous avez une opinion sur la question, une idée, une suggestion? Venez les exposer au congrès de Vancouver du 26 au 30 juin.

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

Appointments: Montreal: *Mrs. Eugenie Wilson* (Vancouver Gen. Hosp.). Sackville: *Frances Cook* (Ottawa Civic Hosp.). Saskatoon: *Margaret Cawsey* (Royal Alexandra Hosp.). Winnipeg: *Olive Blair* (Winnipeg Gen. Hosp.).

Re-appointments: *Mrs. Evelyn (Berens) Cash* to Montreal; *Mrs. Nita (Enns) Seibert* as nurse-in-charge at Peninsula, Ont.; *Winnifred Tredaway* as nurse-in-charge at North Bay; *Marion McEachran* to Regina.

Transfers: *Phyllis Farmer* from Regina to

Prince Albert as nurse-in-charge; *Blanche MacPherson* from Halifax to Yarmouth as nurse-in-charge; *Inez Rickinson* from Peninsula to Lincoln County.

Resignations: *Gwendolyn Angus* from Sackville, *Mildred Irwin* from Calgary, *Constance MacDonald* from Cornwall, *Muriel E. Philip* from Montreal to take up other work; *Isabel Goward* from Prince Albert and *Mrs. Edna (Valiquette) Mulligan*, North Bay, to be married; *Muriel Rice*, North Bay, and *Mrs. Helen Tallman*, Montreal, to attend to home responsibilities; *Mary McLennan* from Vancouver to retire.

The young man who has not shed tears is a savage, and the old man who will not laugh is a fool.

—GEORGE SANTAYANA

Nursing Profiles

When **Ida Evelyn Johnson** entered the school of nursing of the Royal Alexandra Hospital, Edmonton, in 1922 to begin her professional training, she did not dream that in November, 1949, she would step into the role of superintendent of nurses. Born in Cranbrook, B.C., Miss Johnson received her secondary school education in Alberta. A firm believer in the value of post-graduate study, she holds her certificate in operating-room technique from the Woman's Hospital, New York, and in school of nursing administration from the University of Western Ontario, London.

After only four months in private duty following graduation, Miss Johnson became assistant to the operating-room supervisor at R.A.H. She later became the supervisor herself, serving many years in that capacity. For the past five years she has capably filled the position of assistant superintendent of nurses there.

Miss Johnson has always been interested in the work of nursing organizations. She has held numerous offices, including the presidency of both her own alumnae association and of the Alberta Association of Registered Nurses. She is also a firm believer in nurses taking part in community activities. She belongs to the Navy League of Alberta as well as business women's clubs. She is interested in music and plays the piano for her own enjoyment. Gardening and golf provide out-of-doors activity. She receives the greatest pleasure and stimulation from the many

people she has met through all her various contacts, including attendance at the 1949 Conference of the International Council of Nurses.

Miss Johnson has a strong faith in the young women who are entering our schools of nursing that they will accept professional responsibility even as she has through the years.

Myra E. Young, who has been matron of the Fernie (B.C.) General Hospital since 1925, has retired. Graduating in 1912 from the S. R. Smith Infirmary, Staten Island, New York, Miss Young took post-graduate courses in eye, ear, nose and throat work and also in obstetrics. In 1918 she moved to western Canada for reasons of health and engaged in private duty. Later she took an extended course in radiology and x-ray work at the Royal Alexandra Hospital, Edmonton.

This very broad background stood Miss Young in good stead in her early days at Fernie. She was able to fill any role in hospital service and has earned the loyal esteem and gratitude of all the citizens of Fernie because of the skill with which she has coped with difficulties as they have arisen through the years.

Miss Young has been succeeded by **Margaret Saunders**, formerly of Calgary.



Little Studio, London

IDA JOHNSON



MYRA E. YOUNG

Designed to provide medical care at strategic points throughout the vast northland to prevent the spread of disease and to provide emergency nursing service, the Department of National Health and Welfare has appointed **Mrs. Margaret Emond**, a graduate of the Cornwall General Hospital, Ont., to a health outpost at Fort Chimo on Ungava Bay and **Mildred E. Steele**, of Beechy, Sask., to Lake Harbor on Baffin Island.

Gertrude Reid, who has faithfully served in New Toronto as a school nurse since 1923, has retired. At a tea in her honor, representatives of the Board of Health, Board of Education, and town council expressed their appreciation of Miss Reid's splendid work. She was presented with a set of travelling bags in recognition of her services. **Mrs. J. P. LaFlair** has been appointed to succeed Miss Reid.

In Memoriam

George M. Weir, who is best known to Canadian nurses as the author of the "Survey of Nursing Education in Canada," commonly referred to as the "Weir report," died in Vancouver on December 4, 1949, at the age of 64. Dr. Weir had been in failing health since June, 1946.

During his years as provincial secretary in the B.C. legislature, Dr. Weir fought hard to put into effect a program of health insurance which was to have provided benefits for workers earning \$1,800 or less. Although the measure was never enacted because of strong opposition, it became the forerunner of the present B.C. Hospital Insurance Act.

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Ethel M. (Roblin) Beckhorn, who received her nurse's training in Toronto and who went overseas with the Queen's University Hospital Unit in World War I, serving in England and Salonika, died on November 30, 1949, at the age of 59. Mrs. Beckhorn had retired from active work two years ago because of ill health.

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Mary E. (McLeod) Gordon, R.R.C., who served as a nursing sister during World War I in England, France, the Dardenelles, and Egypt, died in Brandon, Man., on November 9, 1949, at the age of 66.

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Susan Haddock, who graduated from the Brandon General Hospital, Man., in 1912,

and who spent 25 years as a missionary nurse in West China, died in Vancouver on October 12, 1949, at the age of 70.

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Jessie McKinnon, who received her nurse's training in Edinburgh and who, years ago, engaged very actively in nursing in and around Portage la Prairie, died on November 19, 1949, at the age of 78.

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Claribel McMillan, an intermediate student nurse at the Stratford General Hospital, Ont., succumbed to injuries received in a car accident on November 4, 1949, at the age of 22.

* * *

Rose Marie Rouse, who graduated from St. Joseph's Hospital, Toronto, in 1925, died on November 30, 1949, at the age of 45. She had been in ill health for the past year. For more than 20 years Miss Rouse had been on the staff of the St. Elizabeth Visiting Nurses Association in Toronto.

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Alice Ellen Stewart, who was superintendent of nurses at the Sherbrooke, (Que.) Hospital from 1898 to 1905, died in Hamilton, Ont., on November 30, 1949.

* * *

Jean Usher, who graduated last year from the University Hospital, Edmonton, died on November 8, 1949, following a brief illness, at the age of 22.

Trends in Nursing

Average reading time — 11 min. 12 sec.

News from the Provinces

British Columbia reports that the Committee on Arrangements, C.N.A., has organized a committee widely representative of Vancouver nurses. They are all looking forward to having the privilege of playing hostess to nurses from all parts of Canada. In December, the Registered Nurses' Association of British Columbia was granted representation on the Survey Committee. Following submission of a brief from the association and a formal request from the University of British Columbia, a grant was received which enabled the Department of Nursing and Health to purchase equipment for a nursing arts laboratory. The provincial government conducted a survey of which Lucile Petry, chief, Division of Nursing, United States Public Health Service, undertook the nursing portion. Miss Petry worked in close co-operation with the association and included in her study the nursing needs of the province so that there is every reason to believe that her recommendations will not be limited to nursing service needs in hospitals.

Amendments to the constitution, approved at the annual meeting, added one new object, namely, "To promote and regulate sound employee-employer relations in the nursing profession." Personnel practices were revised to make the following changes:

1. Basic minimum salary for registered nurses, \$175 per month, subject to adjustments conforming to fluctuations in cost of living index.

2. Differential of \$10.00 between salary for a registered nurse and that for a non-registered nurse.

3. Basis for charges made for residence and meals to be actual cost.

4. A formula for computing the daily wage for temporary employment.

The association is now a party to 13

agreements signed on behalf of the nursing staff of 12 hospitals and one public health service. The association used the National League of Nursing Education State Board tests in the September, 1949, examinations with better than good results. The Student Nurses' Association is active.

Manitoba: Effective January 1, 1950, the Association of Registered Nurses will recognize three types of membership: (1) Active practising membership; (2) active non-practising membership; (3) inactive membership. An Instructors' Workshop was held on June 20, 1949. Approval was given to the \$2.00 per capita affiliation fee to the C.N.A. and to the donation of \$50 to the C.N.A. fund for travel expenses of European nurses to the I.C.N. Conference in Sweden.

It was decided that a Study Committee be appointed by the Board of Managers to consider implications of governmental subsidies for nursing education. The following recommendations were forwarded to the general secretary, C.N.A.:

1. THAT governmental subsidies for nursing education should be allocated at the provincial level of government; that such subsidies be not given to individual student nurses but rather to schools of nursing primarily for improving methods of nursing education, and that the merits of the school of nursing as distinct from its size should determine its eligibility for governmental subsidy.

2. THAT a national survey of nursing service needs should precede any extensive plan for subsidizing nursing education.

3. THAT a commission should be established to act as a policy-forming body and in an advisory capacity to the governmental official or department responsible for the administering of governmental subsidies to schools of nursing if and when such are made; that two-thirds of the members of such com-

mission shall be professional nurses nominated by the provincial registered nurses' association.

New Brunswick: The members of the Institutional Nursing Committee completed the minimum curriculum and it was ready for the fall term. The amendments to the Registered Nurses' Act became effective January 1, 1950. Plans are being made for a nursing school adviser on an inter-provincial basis with the Prince Edward Island. Membership fees were raised to \$10.00 and will include *The Canadian Nurse* and the increased affiliation fee of \$1.00 to the C.N.A.

Nova Scotia: The association has been informed by the Minister of Health that the Ministry proposes to set up a Health Survey Committee for the purpose of determining existing health, hospital, and other related facilities prior to any decision as to allocations from the Federal Health Grant. An Advisory Committee has been set up to facilitate the work of such a Health Survey Committee of which the president of the Registered Nurses' Association is a member. Dalhousie University, Halifax, is giving a post-graduate course in public health nursing and a course for undergraduates. An Educational Policy Committee has been set up under the convenership of Rhoda MacDonald.

Ontario: The new office at 515 Jarvis St., Toronto, will provide a centre for committee meetings. Nettie D. Fidler has resigned as president and Rahno M. Beamish has accepted the office. The Legislation Committee is working on a needed revision of association by-laws. The Continental Casualty Co. group disability plan, sponsored by the association, now covers membership of all districts. The industrial nurses formed a temporary organization of their own in June and are asking that a committee or section, within the association, be formed. There was a lack of interest on the part of students in a student nurses' association.

Prince Edward Island: A new Nurse Practice Act comes into effect January 1, 1950. Four bursaries to graduate

nurses for post-graduate study were given by the provincial Health Planning Commission. Financial assistance from the Health Planning Commission is helping to set up a provincial office and registry. Plans are underway to secure the services of a school of nursing adviser jointly with New Brunswick.

Quebec: A provincial survey is being conducted under the direction of Dr. J. E. Sylvestre. Suzanne Giroux is active on the sub-committee on Professional Training. Twenty-one displaced European nurses are enrolled as nursing aides in hospitals. These nurses require a centralized plan of instruction, designed to meet their needs, to supply deficiencies and to prepare the group for licensing and the practice of nursing. Through the co-operation of McGill School for Graduate Nurses and of the Children's Memorial Hospital, a course of instruction in pediatric nursing is being arranged.

Saskatchewan: Lola Wilson has been appointed assistant registrar. Six bursaries were awarded to nurses for post-graduate work. The special studies of the health program have continued. The Health Services Planning Commission accepted responsibility for the technical work of the study made during the summer. Revision of recommendations, relating to nursing personnel, is planned. An affiliation in psychiatry at the Munroe Wing, Regina General Hospital, has been organized on an experimental basis by funds from the Federal Grant. Re-organization of examinations for nurse registration is under consideration. A grant of \$1,500, to assist with the work of Nurse Placement Service, has been received from the provincial government. A willingness to increase the annual fee to the C.N.A. in 1950 to \$2.00, if this policy is generally endorsed by other provinces, was reported.

Educational Policy Committee

Evaluation of schools of nursing: No steps have been taken to enlarge the provisional committee to study eval-

uation in view of the fact that at the last Executive meeting the resolution, recommending that a national program of evaluation should be instituted by the C.N.A., was tabled. However, in view of the fact that evaluation is one of the Work Conference topics at the forthcoming biennial, a small Montreal provisional committee has continued to meet. Margaret Street, the convener, reported upon an institute which she had attended in New York recently, in which the technique of evaluation was dealt with very effectively.

The members were interested in her report and in what has been done in the U.S.A. (See the October, 1949, *A.J.N.* for the editorial on "Accreditation and Classification" and the first release by the National Nursing Accrediting Service, 1949, of approved programs in nursing.) It was felt that we must avoid any tendency to establish too uniform a level in our schools, that only basic requirements should be considered in evaluation, and that scope must be allowed for variation and research.

It was decided that the present provisional committee should keep in touch with evaluation programs so that we will be prepared to supply leadership when funds are available for evaluation in Canada. The following motions were carried:

THAT the Provisional Committee on Evaluation of Schools of Nursing make a study of the cost of evaluation for our information.

THAT the Committee on Educational Policy affirm its belief in the principle of nationally organized professional nursing groups assuming responsibility for accreditation on a national basis of educational programs in nursing.

THAT the Executive Committee, C.N.A., be requested to take active measures to implement a national program of evaluation of schools of nursing as a first step toward the establishment of a national program for the accreditation of all educational programs of nursing.

The ratification of these motions was given by the Executive Committee.

Government support for nursing education: At the C.N.A. Executive meeting, held in Winnipeg in March, 1948, the following resolution was passed:

THAT the Committee on Educational Policy be asked to study the question of government support of education in various fields, and the conditions under which the professions concerned feel that it is satisfactory, and to bring in a suggested educational policy for the C.N.A.

Nothing could be done before the C.N.A. met in Sackville but, in discussing the possibilities of such a study at the first Executive meeting afterwards, it was agreed that, before the chairman could proceed to undertake this commission, we needed technical, particularly statistical, help; that we needed a full-time person as an educational secretary to make personal contacts and get information as well as to develop some kind of interviewing technique. It was also necessary for us to know whether, if some worthwhile program involving support by government funds was proposed, it would have professional backing in all the provinces.

At the request of the Educational Policy Committee the general secretary asked the provincial associations' approval or otherwise of a plan being brought forward for consideration, which would involve seeking governmental support for nursing education.

When the provincial replies were available, the general consensus was that they favored the principle of government-supported nursing education, providing the nursing profession is able to retain the necessary supervisory control.

There was discussion on the relative values of making our own approach to government or joining other groups, as was done through the C.N.A. Joint Committee (C.M.A., C.H.C., and C.N.A.) when an approach was made to the Minister of Health and Welfare for financial support to conduct a national survey of nursing. It was agreed that before

any further approach to government is made we nurses need to know what it is we want to propose. There is some urgency, if the Metropolitan School of Nursing is to continue as an independent school, that every channel of possible income be pursued.

The following motion was approved:

THAT Agnes Macleod be appointed chairman of a Core Committee, selected by herself, to initiate action immediately on the previous recommendation regarding the approach to governments for financial aid for nursing education.

Delineation of functions: The provincial associations did not agree with the resolution concerning the inclusion of intravenous therapy in the basic nursing course, although replies were not received from all of them. There can be no further action at this time, although it behooves all of the nursing service administrators to know whether this procedure is being carried out by nurses in their areas of control or not, and that, if there is necessity for such practice, the graduate nurses are given sufficient instruction to ensure safety in their technique.

Sub-committee on Auxiliary Workers: The following amended resolution was passed:

WHEREAS, It is becoming increasingly apparent that there is an urgent need for clarifying the scope of and the relationship between the professional and the auxiliary nursing fields; and

WHEREAS, Such clarification is in the interests both of the public and of the professional and the auxiliary nursing groups; therefore be it

Resolved, That the Committee on Educational Policy recommend that the Executive Committee, C.N.A., refer to the provincial Committees on Educational Policy the need for a study of the

functions of the professional nurse and those of the auxiliary nursing worker, with the purpose of making a more precise delineation of professional nursing and of auxiliary nursing.

Metropolitan School of Nursing

Registration of graduates: The first and second groups have all successfully passed the Ontario Registration Examination, Part I. The first group wrote the final registration examination in November, 1949.

Reciprocal registration: At a meeting of the Demonstration School Administration Committee it was decided to write to the provincial associations, asking them if they could state whether the graduates of the Metropolitan School, who are eligible for registration in Ontario, would have the same privileges of reciprocity that the graduates of other approved Ontario schools enjoy. From replies received, it would appear that this matter is satisfactorily cleared in seven provinces. The Registered Nurses' Association of Nova Scotia writes that if, as is hoped, their Bill is passed in the spring of 1950, it will contain a provision for granting reciprocal registration to graduates of the school. A final reply has not yet been received from Alberta.

Students: Class of Spring, 1950—One married student withdrew on the advice of her physician. The group now numbers 11. Class of Autumn, 1950—Of the original group of 24, one student withdrew to be married. Class of 1951—24 students were admitted on Sept. 12, 1949. For this class there were: Enquiries, 317; applications, 75; refused and withdrawn, 51. Class to be admitted in Sept. 1950—Enquiries, 27; applications, 8.

Christian Fellowship

Plans for a graduate nurses' Christian Fellowship in Vancouver have materialized. The group convenes the second Monday of each month at the home of the president, Miss Mary Bell, 2718 Alberta St., Vancouver, B.C.

All visiting graduates are welcome. We would be pleased to correspond with members of any similar group.

Orientation et Tendances en Nursing

NOUVELLES DES PROVINCES

Colombie-Britannique: En vue du congrès biennal, l'Association des Infirmières du Canada a organisé un comité du programme dont les membres sont en grande partie de Vancouver. Elles anticipent le privilège de recevoir les infirmières du Canada. En décembre, l'on accorda à l'Association des Infirmières Enregistrées de la Colombie-Britannique d'être représentée sur le comité de l'enquête des services de santé.

Le Département du Nursing et de la Santé de l'Université de la Colombie-Britannique organise un laboratoire sur l'art du nursing, un octroi leur a été accordé à cet effet, à la suite d'un exposé présenté par l'association des infirmières de cette province et d'une demande dans le même sens faite par l'université.

Le gouvernement de la province a fait une enquête sur les services de santé. La partie concernant les infirmières fut confiée à Lucile Petry, de la section du nursing du Département de la Santé Publique des Etats-Unis. Mlle Petry a travaillé en co-opération étroite avec l'A.I.C.B. Elle a inclus dans ce travail sur le nursing les besoins de la population, ce qui porte à croire que ses recommandations ne se limiteront pas aux besoins des hôpitaux.

Les constitutions de l'association ont été amendées et le but suivant, comme fin à atteindre, a été ajouté: "Promouvoir et réglementer une bonne entente entre employeur et employées dans la profession d'infirmière." Le salaire minimum de \$175 a été recommandé pour les infirmières enregistrées. Les repas et le logement seront chargés au prix courant. L'association est agent mandataire et a signé des conventions collectives pour 12 groupes d'infirmières dans les hôpitaux et un groupe en hygiène publique.

A titre d'expérience, les élèves infirmières de cette province ont passé les examens de la "National League of Nursing Education"; elles ont remportées un succès éclatant.

Manitoba: L'Association des Infirmières Enregistrées du Manitoba a approuvé qu'une cotisation de \$2.00 par membre, soit versée à l'Association des Infirmières du Canada.

Un comité fut nommé dans le but d'étudier l'octroi de subsides pour l'éducation des Infirmières. Il fut recommandé que:

(1) Toute aide, accordée par le gouvernement, soit versée à l'école plutôt qu'aux élèves individuellement; que ces octrois versés aux écoles le soit dans le but d'améliorer les méthodes dans l'éducation de l'infirmière; que ces octrois soient versés d'après la valeur de l'école et non d'après la dimension de l'école.

(2) Qu'une enquête nationale sur les besoins de la population, en regard des infirmières, soit tenue avant qu'il soit question de verser des octrois aux écoles d'infirmières.

(3) Que, si la recommandation de verser des octrois aux écoles d'infirmières est acceptée par le gouvernement, un comité consultatif soit formé dont les 2/3 seraient des infirmières nommées par l'association des infirmières de la province.

Nouveau-Brunswick: Le programme scolaire pour les élèves infirmières vient d'être terminé et était en usage lors de l'ouverture des cours en septembre dernier.

L'association provinciale a approuvé d'augmenter d'un dollar par membre la cotisation à l'A.I.C. La cotisation payable par chaque infirmière de l'Association des Infirmières Enregistrées du N.B. est de \$10.00 et chaque membre reçoit la revue, *The Canadian Nurse*.

Nouvelle-Ecosse: Le Ministère de la Santé a informé l'Association des Infirmières Enregistrées de la Nouvelle-Ecosse qu'un comité sera formé dans le but de faire un relevé de toutes les organisations de santé, hôpitaux, associations, etc., en existence avant qu'il soit question d'octrois fédéraux de santé. L'Université de Dalhousie, Halifax, donne un cours post-scolaire en hygiène publique et un autre cours sur la même matière aux élèves infirmières.

Ontario: La nouvelle présidente de l'Association des Infirmières Enregistrées de l'Ontario est Rahno M. Beamish. Elle remplace Nettie D. Fidler.

Tous les districts de la province ont des infirmières faisant partie de l'assurance groupe de Continental Casualty Co. Les infirmières employées en industrie se sont organisées en un groupe particulier et elles ont demandé à l'association de former un comité ou une section permanente de leur groupe.

Ile du Prince-Edouard: Une nouvelle loi, régissant la profession d'infirmière, est entrée en vigueur en janvier. Quatre infir-

mières ont reçu des bourses d'étude, provenant des octrois des services de santé. Des subsides, provenant de la même source, permettront d'organiser un bureau et un registre provincial.

Québec: Un relevé provincial est actuellement dirigé par le Dr. J. E. Sylvestre du Ministère de la Santé. Un des membres, Suzanne Giroux, travaille activement au sous-comité de la formation professionnelle.

Vingt et une infirmières, déportées d'Europe, ont été placées comme aides dans nos hôpitaux. Un programme d'étude, spécialement organisé pour elles, leur est donné en vue de les préparer aux examens.

Saskatchewan: Une affiliation en psychiatrie a été organisée à titre d'expérience, grâce à l'aide obtenue provenant des octrois des services de santé. Le bureau de placement pour les infirmières a reçu \$1,500 du gouvernement provincial.

L'Association des Infirmières Enregistrées de la Saskatchewan est prête à augmenter à \$2.00 la cotisation payable à l'A.I.C. si le même geste est fait par les autres provinces.

LE COMITÉ DE L'ÉDUCATION

(Chargé de déterminer la politique adoptée par l'Association des Infirmières du Canada en matière d'éducation)

Évaluation des écoles d'infirmières: Rien n'a été fait pour augmenter le nombre des membres de ce comité chargé d'étudier la recommandation d'instituer un programme national d'évaluation des écoles d'infirmières, étant donné que ce projet a été ajourné lors de la réunion du conseil de l'A.I.C. Néanmoins, l'évaluation des écoles sera le sujet d'une conférence d'étude lors du congrès biennal. A Montréal un petit comité continue à étudier cette question. La convocatrice, Margaret Street, a assisté à des journées d'études à New York où la technique de l'évaluation et sa valeur ont été démontrées.

Le gouvernement doit-il prendre à sa charge les écoles d'infirmières? Lors de la réunion du Comité de Régie de l'A.I.C., tenue à Winnipeg en mars, 1948, la résolution suivante fut approuvée:

"Que le Comité de l'Éducation soit chargé d'étudier l'aide que le gouvernement apporte à l'éducation dans différents domaines et à

quelles conditions cette aide pourrait contribuer d'un manière satisfaisante à mettre en pratique la politique recommandée pour la profession d'infirmière."

Avant de faire des démarches auprès du ou des gouvernements, la convocatrice du Comité de l'Éducation aurait besoin de certaines statistiques; en plus elle estime qu'une secrétaire employée à temps complet serait nécessaire.

Sous-Comité des Aides: Il semble urgent de mettre au point quel est le domaine de l'aide en rapport du domaine réservé à l'infirmière. Il a été proposé que tous les comités provinciaux de l'éducation étudient les fonctions réservées à l'infirmière et celles qui peuvent être confiées aux aides, afin qu'une ligne de démarcation soit tracée entre les deux.

L'ÉCOLE D'INFIRMIÈRES METROPOLITAN

L'enregistrement des diplômées: Deux groupes d'élèves ont passé avec succès les examens d'enregistrement de l'Ontario. Le premier groupe a passé les examens finals en novembre 1949, et le deuxième a passé l'examen d'enregistrement de la première année.

L'enregistrement par réciprocité: Le Comité d'Administration de l'École de Démonstration Metropolitan a décidé d'écrire aux associations provinciales, afin de savoir si les diplômées de l'école, ayant obtenu leur enregistrement dans l'Ontario, pourront obtenir l'enregistrement dans les autres provinces. D'après les réponses reçues de sept provinces, il semble décidé que les provinces accorderont le privilège de l'enregistrement à ces élèves. L'Association des Infirmières Enregistrées de la Nouvelle-Ecosse espère pouvoir répondre dans le même sens lorsque la nouvelle loi des infirmières sera adoptée. Une dernière réponse est attendue de l'Alberta.

Elèves: La classe, devant graduer au printemps 1950, compte 11 élèves; une élève mariée s'est retirée sur le conseil de son médecin. La classe de l'automne 1950, compte 23 élèves; une est partie pour se marier. La classe de 1951 compte 24 élèves. Pour cette dernière entrée 317 demandes d'information furent reçues, 75 demandes furent faites, et 51 candidates furent refusées ou se retirèrent d'elles-mêmes.

Age selection pattern of poliomyelitis in Canada, with the exception of the 0-4 age group, has shown little change. While it may attack any person in any age group from 0 to over 50, the most susceptible age group at present is 5-9.



JUNE IN VANCOUVER

Isn't it lovely at this time of year to think of June in Vancouver and of meeting and conferring with friends on the beautiful University of British Columbia campus overlooking the Sound? We hope, if the weather is kind, that many of the discussion groups will meet out of doors and that, while we are refreshing our minds, our bodies may luxuriate in the sights and scents of summer days.

The following outline will give you a preview of what the consulting team on Evaluation and Accreditation of Schools of Nursing is preparing for us. Dorothy G. Riddell, inspector of Training Schools for Nurses, Ontario Department of Health, has been added to the team of consultants noted in the January issue.

GENERAL PLAN FOR CONFERENCES

General aim—To acquaint the faculty members of schools of nursing and all concerned with educational programs in nursing with current trends in evaluation and accreditation programs in order to develop interest that may stimulate a desire for more knowledge on this subject and lead to some definite action.

Conference purposes—(1) To discuss the meaning of the terms "evaluation" and "accreditation." (2) To consider methods employed in evaluating and accrediting educational programs in schools of nursing. (3) To consider why an evaluation and accreditation program is indicated, what it proposes to do, and the profession's responsibility for inaugurating such a program. (4) To consider how evaluation and accreditation can improve nursing education, nursing

service, and health standards in your community. (5) To consider plans for implementing an evaluation and accreditation program in Canada.

Methods—These conferences are to be conducted as active discussion groups. Individual groups may concentrate on the area of particular interest to them. There will be a chairman, a secretary, and an observer for each group. Group reports will be mimeographed and available for all members.

Plan—Work conference will extend from June 27 to 29 from 2:00 to 5:00 p.m.

Registration for each conference will be limited in the interest of good discussion. Those wishing to attend this conference should make application at the earliest possible date. Application forms will be available through your provincial office.

The same general pattern will be followed for each work conference, as follows:

FIRST DAY—*Total group*: (a) Brief introduction to work conference method. (b) Introduction to conferences (panel). *Small groups*: Development of group objectives. Anticipated results of an evaluation program from point of view of: (a) Hospital administration. (b) Nursing education. (c) Nursing service. (d) Profession of nursing.

SECOND DAY—*Total group*: The accreditation process. *Small groups*: Preparation for the school visit: (a) Participation of hospital board. (b) Co-operation of faculty members in preliminary work. (c) Function of visitor in relation to school. (d) Interpretation of visitor's report.

THIRD DAY—*Small groups*: Methods of interpreting need for program. *Total*

group: Implementation of program in Canada.

TRANSPORTATION

The October number of the *Journal* carried information secured through the courtesy of Trans-Canada Air Lines on air travel plans to Vancouver. Rates were quoted for groups of ten or more travelling together. A recent letter has further interpreted this group scheme:

Group rates apply when a party of ten or more travel from a common point of

origination to one destination. On the outward trip members of the group must travel within 24 hours of the first one of the party. For the return trip the group members can return individually, leaving when they so desire up to four months from the date the ticket was purchased. For example—Five people leave Montreal on June 10 and five on June 11 for Vancouver, returning from Vancouver on separate dates with all the privileges of a regular ticket, regarding time of departure stop-overs, and routings.

In The Good Old Days

(The Canadian Nurse, February 1910)

"Montreal is just recovering from a typhoid epidemic—an epidemic which was alarming because it seemed loath to abate . . . There were some three thousand cases in the city with many new cases being reported daily . . . An emergency hospital (with) the Victorian Order nurses to attend to the nursing was launched . . . in a large factory on Aqueduct Street . . . Saturday, the dust-laden factory; Tuesday, a clean, well-equipped hospital, with every appliance at hand to bring back the sick to health and vigor."

* * *

"Teachers College is about to inaugurate, through its new School of Household Arts, a public service movement of large promise. In brief, the college plans to train a body of teacher-nurses to carry the theory and practice of physical welfare for children and of hygienic living in general into homes, schools, and communities. Through the munificence of Mrs. Helen Hartley Jenkins, an endowment has been provided for instruction in the science and art of hygienic living, with the special object of training women for public services as visiting nurses in home and school, teachers in farmers' institutes, and sanitary

experts in the training of children in city and country."

* * *

"The Welfare Committee (in Toronto) hopes ere long to open pure milk depots where mothers can secure the best milk obtainable at a nominal cost, and hope the day is not far distant when 3-cent lunches will be served in our public schools, as is done in New York, as the child of the working mother has little chance of much nourishment at noon hour and soon may the need of school baths be recognized by those in authority."

* * *

"The Ladies' Auxiliary for Kincardine Hospital are desirous of acquainting any parties who would like to contribute feathers for hospital pillows that they will be pleased to furnish the ticks for them."

* * *

"The nurses' home at the G. & M., St. Catharines, is to be enlarged and improved. The new operating equipment is first class, so is the steam table in the diet kitchen. Our staff doctors are giving the nurses splendid lectures again this year."

The WHO special committee that has been studying the action of various insecticides has found that "in certain countries the control of anophelines by spraying with residual-action insecticides has, in the absence of any sanitary methods, contributed to the disappearance of flies, whose importance in the propagation of disease is becoming more and more widely recognized.

"However, to make the best use of new

insecticides, it is essential in fly control to ascertain certain useful biological data, such as their habits and habitat. As it has been recorded that strains of houseflies, which are resistant to DDT, have evolved after DDT-treatment of dwelling places, it is preferable to use other insecticides, such as chlordane or BHC. Research should be carried out on the possibility of prolonging the residual action of these insecticides."

Methemoglobinemia

ISABEL E. MACLACHLAN

Average reading time — 7 min. 48 sec.

SANDY, AGED SIX WEEKS, was the fourth child of healthy, normal parents who lived on a farm. The other three children were all healthy. Sandy had weighed six pounds at birth and had developed well as a bottle-fed baby. Occasionally he vomited slightly following his feedings. No significance was attached to this at the time.

On the day of admission to hospital, Sandy had had his first bottle of the day at 4:30 a.m. When his mother put him back into his bed, he appeared normal in every way. Yet when she went to him at 6:15 a.m., she found Sandy was breathing with great difficulty and was cyanosed. It was a distance to hospital but as soon as he had been admitted at 11:40 a.m., oxygen with carbogen 7% was administered every 20 minutes for 5 minutes, by mask. When Sandy was taken to the x-ray for chest examination, the oxygen therapy was continued uninterruptedly.

Penicillin was ordered by the doctor—20,000 units immediately followed by 10,000 units every 3 hours. An intravenous of glucose was started as Sandy was given nothing by mouth. The x-ray findings were essentially normal with "no opacities apparent within the lung fields to indicate gross lesion." The laboratory report on the blood tests showed a white blood cell count of 20,600 with toxic granulation present. The urine was slightly cloudy with approximately 10% methemoglobin present in the specimen.

Despite the continued oxygen thera-

py, no improvement in Sandy's color was noted. This, coupled with the laboratory findings, led to the conclusion that he had methemoglobinemia. Therefore, 0.5 cc. of methylene blue, 1%, was given via the intravenous.

Experimentally, methylene blue converts methemoglobin into hemoglobin within 10 minutes, provided the methemoglobin content in the blood has not risen to more than 40 per cent of the total pigment. One milligram per kilogram of body weight is given intravenously to produce this effect. An infant weighing 8 pounds should thus respond to a dose of 0.5 cc.

After the first injection, Sandy's color improved slightly and his respirations became less labored. A second dose was administered half an hour later. By the next morning, his color and respirations were good. He appeared hungry and took the glucose eagerly. All treatments were discontinued and he was placed on a formula using skimmed milk.

Sandy's home was dependent on a well for its water supply. In order to prove that this water was the source of the difficulty, it was arranged that 20 ounces of this well water would be delivered to the hospital to be used in the preparation of the formula. The immediate result was a return of the mottling on the baby's skin. The following day, city water was used in making the feedings. Gradually the discoloration diminished, appearing only slightly when he cried. A week after his admission, Sandy was discharged. During his stay in hospital, the baby's weight had increased approximately half a pound.

Miss MacLachlan is a student nurse at the Regina General Hospital, Sask.

Tests were made on the farm well water. The specimens showed the following results:

(a) *Pumped water*: "Nitrate content 30 times the limit considered safe for infants."

(b) *Pulled sample*: "Nitrate content almost double that of the above test."

The pumped specimen showed no harmful organisms whereas the pulled water, which was drawn several days later, contained "a high degree of bacterial contamination." The different findings were possibly due to the fact that when the parents realized that the well water was the cause of their baby's ailment they stopped using it.

Methemoglobinemia was little known until 1945 when a doctor reported two cases in infants in rural Iowa. Both babies were on artificial feedings made up with well water of high nitrate content. Following publication of his report, many more cases came to light, including 12 patients in rural Manitoba and Ontario. Despite incomplete data on all of these, it can be assumed the diagnosis was the same since their histories were typical and recovery complete as soon as the suspected well water was discontinued. In each instance the patient was an infant under two months of age, fed on an evaporated or powdered milk formula.

The water used in every case came from poorly constructed shallow wells, often situated on low ground and in close proximity to animal contamination. The safe upper limit of nitrate content in well water is placed at 10 parts per million. Wells that have been contaminated by seepage from manure piles, pig-pens, etc., contain an excessive amount of nitrate, in some cases 200 to 300 parts per million.

Methemoglobin is normally present in blood to extent of 1 per cent. Methemoglobin is in itself non-toxic but, as it is unable to carry oxygen, cyanosis and even death may result, if any appreciable quantity of the hemoglobin is transformed into methemoglobin. When water containing nitrates in the safe amount is ingested, they are rapidly reduced to nitrites,

then to ammonia and are excreted as such. When greatly increased quantities of nitrates are ingested, either due to nitrate-containing drugs or to contaminated well water as in Sandy's case, the normal mechanism is evidently inadequate. The nitrates are broken down to nitrites and are absorbed as such into the circulation. One molecule of nitrite iron unites with two molecules of hemoglobin to form methemoglobin. In some of the reported cases the methemoglobin level has reached 6 or 7 grams, thus leaving only 5 or 6 grams of functioning hemoglobin.

WHAT I HAVE LEARNED

1. Well water methemoglobinemia should be considered as a possible diagnosis in all cases of cyanosis in rural infants under two months of age who are artificially fed (often confused with congenital heart or "enlarged thymus").
2. It does not occur in the breast-fed infant nor in the infant fed undiluted cow's milk.
3. Its occurrence depends on an excess of nitrate present in contaminated well water used in making up infant feedings.
4. Boiling the water has no effect on the nitrate content.
5. Infants recover spontaneously within 36 hours after the correct diagnosis is made and the use of the contaminated well water stopped.
6. Blood tests show blood to be a chocolate-colored fluid which on spectroscopic examination shows a well-marked methemoglobin band.
7. Public health measures should be urged to improve the quality of rural water supplies and prevent the use of any water containing more than 10 parts per million of nitrate in infant formula.

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The Death of Oliver Cromwell

RECENTLY, WE WERE privileged to examine a very old newspaper, *The Commonwealth Mercury*, that was published in London, England, as a weekly, covering the events from September 2 to 9, 1658. Each page was slightly smaller than our *Journal* page. There, heavily bordered in black, was the announcement of Cromwell's death. We reproduce part of it with the original spelling and capitalization, though we cannot use the old style "s" that looks like an "f."

The advertisements gave us all a chuckle, too, so we shall share them with you, exactly as they were worded.

His most Serene and Renowned Highness Oliver Lord Protector, being after a sickness of about fourteen days (which appeared an Ague in the beginning) reduced to a very low condition of Body, began early this morning to draw near the gate of death; and it pleased God about three a clock afternoon, to put a period to his life. I would willingly express upon this sad occasion, the deep sorrow which hath possessed the mindes of his most Noble Son and Successor, and other dearest Relations, had I language sufficient: But all that I can use, will fall short of the merits of that most excellent Prince. His first undertakings for the Public Interest, his working things all along, as it were out of the Rock, his founding a Military Discipline in these Nations, such as is not to be found in any example of preceding times; and whereby the Noble Soldiery of these Nations may (without flattery) be commended for Piety, Moderation, and Obedience, as a pattern to be imitated, but hardly to be equalled by succeeding generations: His Wisdom and Piety in things divine, his Prudence in management of the Civil Affairs, and conduct of the Military, and admirable Successes in all, made him a Prince indeed among the people of God; by whose prayers being lifted up to the supreme Dignity, he became more highly seated in their hearts, because in all his actings it was evident, that the main design was to make his own interest one and the same

with theirs, that it might be subserving to the great interest of Jesus Christ.

And in the promoting of this, his spirit knew no bounds, his affection could not be confined at home, but brake forth into foreign parts, where he was by good men universally admired as an extraordinary person raised up by God, and by them owned as the great Protector and Patron of the Evangelical Profession. This being said, and the World itself witness of it, I can onely adde, That God gave him blessings proportionable to all these virtues, and made him a Blessing to us, by his wisdom and valor to secure our Peace and Liberty, and to revive the ancient renown and reputation of our Native Country.

After all this, it is remarkable, how it pleased the Lord, on this day to take him to rest, it having formerly been a day of labors to him; for which both himself and the day (*Sept. 3*) will be most renowned to posterity, it having been to him a day of Triumphs and Thanksgiving for the memorable Victories of *Dunbar* and *Worcester*; a day, which after so many strange Revolutions of Providence, high Contradictions, and wicked Conspiracies of unreasonable men, he lived once again to see, and then to die with great assurances and serenity of minde, peaceably in his Bed.

Thus it hath proved to him to be a day of Triumph indeed, there being much of Providence in it, that after so glorious Crowns of Victory placed on his head by God on this day, having neglected an Earthly Crown, he should now go to receive the Crown of Everlasting Life.

... This Afternoon the Physitians and Chirurgians appointed by Order of the Council to embowel and embalme the Body of his late Highness, and fill the same with sweet Odours, performed their duty.

* * *

ADVERTISEMENTS

There is newly Published, a few Sighs from Hell, or the Groans of a damned Soul, being an Exposition of those words in the Sixteenth of Luke, concerning the Rich Man and the Beggar; wherein



You know, you do more for your patient than you might think . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. *Because perspiration is a continuous process.*

Mum is the *safer* way to preserve morning-bath freshness because it contains no harsh or irritating ingredients—stays smooth and creamy—does not dry out in the jar. And Mum is *sure* because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

Why take a chance when
you can MUM in a moment?

Safer for charm . . .

Safer for skin . . .

Safer for clothes . . .





WHITE UNIFORM SHOES

Because they are light and airy, attractively styled, and because they are designed on Hurlbut lasts to stand up to a lot of standing up and walking about, "White Uniform" shoes by Savage are the choice of smart young women in the nursing profession.



THE Savage Shoe

COMPANY LIMITED
PRESTON, ONTARIO


is discovered the lamentable state of the damned, their cries, their desires in their distresses, with the determination of God upon them: A good warning word to sinners, both old and yong, to take into consideration betimes, lest they come into the same place of torment. Also a brief discourse touching the profitableness of the holy Scriptures. By that poor servant of Jesus Christ, John Bunyan. Sold by M. Wright at the King's-Head in the Old-Bailey.

That excellent, and by all Physicians approved, China Drink, called by the Chineans, Tcha, by other Nations, Tay or Tee, is sold at the Sultaness-head, a Cophee-house in Sweetings Rents by the Royal Exchange, London.

Whosoever desireth to be cured of the Rupture, or Broken Belly, of any ages to threescore and ten, let them repair to one Rowland Pippin, who will by Gods help make them whole; the poor for

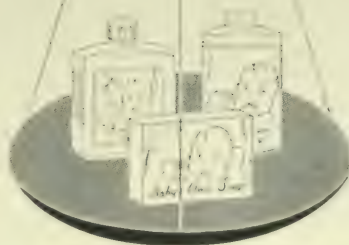
charity, the mean for little, the rich for reasonable terms: He will stand to all charge for the Cure, until they shall finde by experience their own good. He hath taken a Chamber in the Strand, at the Three Pigeons near Somerset-house, where you may finde him all the Fore-noons until nine of the clock, and from one to five in the afternoon. He lives in the countrey at Sutton-Brewhouse near Gilford in Surrey; his Father, Brother, and himself, have used this practice this threescore years in the West, where the name of Pippin is remarkable for several cures of this nature.

Sept. 3, in the night, was stole or lost from Mr. Allen's pasture in Hasleigh near Maldon in Essex, a well spread Bay Gelding about 15 hand high, with a black mane and tail, a great white blaze in his face, almost ball-faced, the skin of his upper lip white, three white feet, a knot upon one of his fore-legs like a splint, between the knee and the pastern, half



a trio of products you can trust

... recommend them
with confidence



BABY'S OWN SOAP

BABY'S OWN POWDER

BABY'S OWN OIL

With the greatest respect for your opinion and the fullest confidence in our products, we submit Baby's Own Soap, Oil (contains no antiseptic) and Powder — a trio of trusted baby toiletries — for your recommendation to mothers for safe, efficient baby care.

The same careful control of ingredients that has established confidence in the Baby's Own name for many years is constantly maintained in all three products. Backed by the approval of dermatologists, we offer Baby's Own products for their purity and gentleness in caring for even the most sensitive skin.

BABY'S OWN

Soap - Oil - Powder

The J. B. Williams Co. (Canada) Limited
La Salle, P.Q.

How Heinz safeguards the babies in your care



Heinz Baby Foods are dated to ensure fresh stocks

Every tin of Heinz Strained and Junior Foods carries a *code number*, showing the date it was packed—the day and the year. Heinz salesmen check these numbers when they make their frequent visits to grocers' and drug-gists' stores, to make certain that the supplies in stock are always fresh.

Heinz takes this *special precaution* in order to be

doubly sure that infants will get foods of the fine fresh quality that is so important in baby diets.

This checking at the point of sale is the last of several steps Heinz takes—from the selection and cleansing of the raw materials, through to the Quality Control Laboratories—all aimed at inspiring confidence in its products among doctors, nurses and mothers.

Heinz Baby Foods

57

27 STRAINED FOODS, 17 JUNIOR FOODS, 2 BABY CEREALS

VOLUME 46
NUMBER 3
MONTREAL
MARCH
1950



THE CANADIAN NURSE

C.N.A. BIENNIAL
CONVENTION

June 26-30

Vancouver, B.C.

SYMPOSIUM ON
EPILEPSY

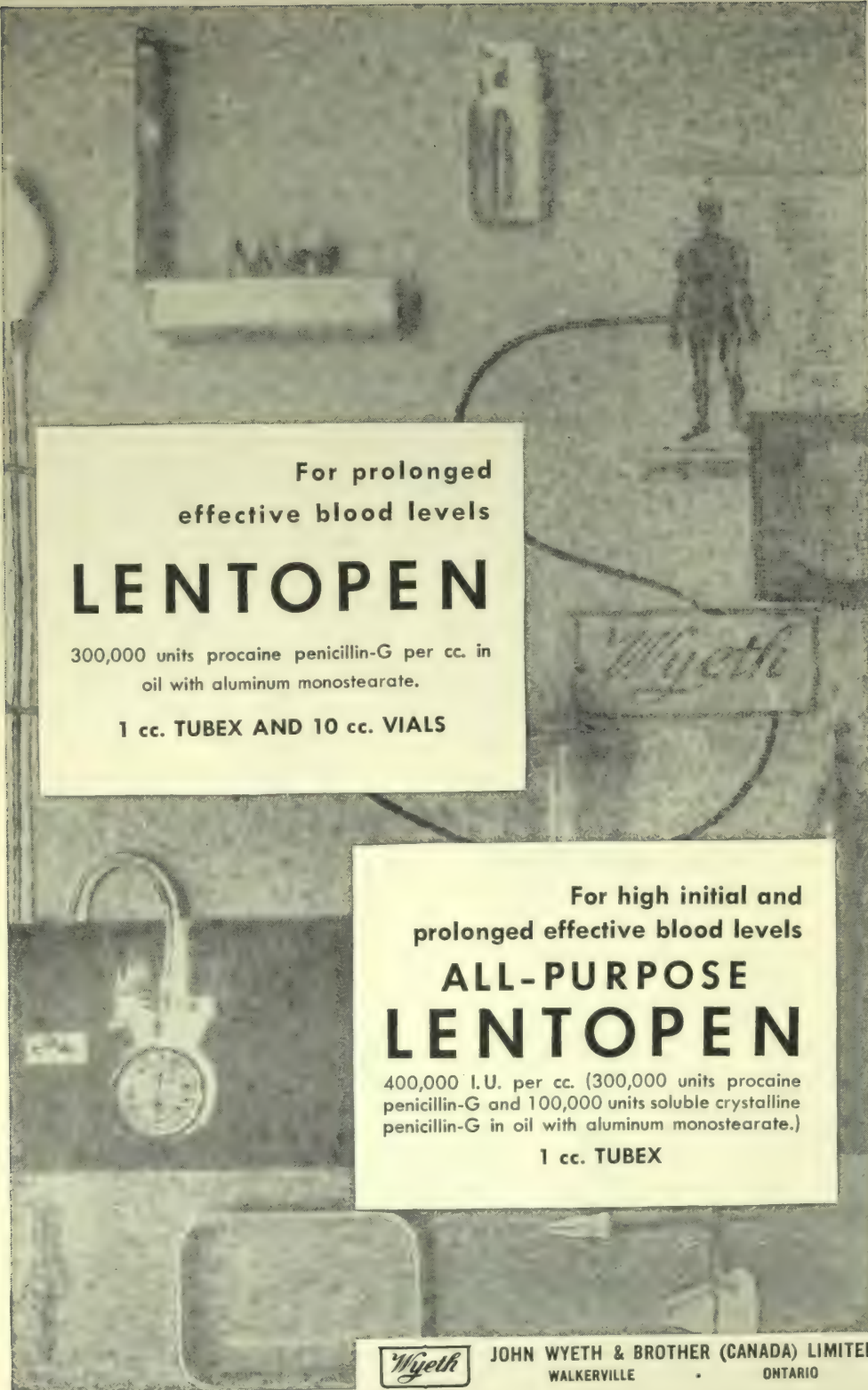


BRONCHOSCOPY

See page 173



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For prolonged
effective blood levels

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300,000 units procaine penicillin-G per cc. in
oil with aluminum monostearate.

1 cc. TUBEX AND 10 cc. VIALS

For high initial and
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ALL-PURPOSE LENTOPEN

400,000 I.U. per cc. (300,000 units procaine
penicillin-G and 100,000 units soluble crystalline
penicillin-G in oil with aluminum monostearate.)

1 cc. TUBEX



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WALKERVILLE • ONTARIO



HANDS LOOK LOVELIER IN 24 HRS. ...OR YOUR MONEY BACK!

**Red, rough chapped hands are a
real "occupational hazard"
of nursing**

● Probably no hands in the world take more punishment than those of a nurse. That's why they need something more than perfumed hand prettiers. Nurses must be sure the care they give their hands will protect them at all times from the damaging effects of hospital and medical chores.

Years ago nurses first discovered Noxzema—a dainty, greaseless way to help their red, rough hands look softer, whiter. Today, *medicated* Noxzema Skin Cream is more popular with nurses than ever before.

Noxzema is *greaseless*. That's very important! No worry about soiling clothing or uniforms. It's *medicated*—a unique oil-and-moisture formula that helps supply a protective film to the skin's outer surface.

And even more important to you—Noxzema has been clinically-tested! A skin specialist found in tests that 9 out of 10 women showed softer, whiter, lovelier-looking hands—extraordinary improvement in just 24 hours.

Try Noxzema Skin Cream on your own hands tonight. So sure are we that results will delight you we make this sincere money-back offer. If you don't see a noticeable improvement by tomorrow, if you're not thrilled to find your hands look lovelier even in 24 hours—return the jar—your money cheerfully refunded.

But you *will* be delighted at the way this dainty, greaseless cream helps your hands look softer, whiter, lovelier. Available at all drug and cosmetic counters. Try a jar of Noxzema today.

FOR YOUR PATIENTS' COMFORT

Try Noxzema Skin Cream to help heal the sore irritation of patients' sheet burns. They'll appreciate the delightful soothing relief they get from Noxzema's *medicated* formula. And here's a *new idea* in skin comfort they'll love! Use this dainty greaseless cream as a refreshing body massage. It's a wonderful skin tonic—will make them feel good *all over*! Noxzema is greaseless—so there's no worry about staining bed linen. Start using Noxzema today.

The Canadian Nurse

VOLUME 46

NUMBER 3

MARCH, 1950

NEW PRODUCTS.....	166
GREAT EXPECTATIONS.....	<i>M. K. Miller</i> 171
CANCER RESEARCH IN PICTURES.....	<i>L. St. Maurice</i> 173
DIAGNOSIS AND TREATMENT OF EPILEPSY.....	<i>C. E. Gould, M.D.</i> 177
EMPLOYMENT OF THE EPILEPTIC.....	The late <i>H. E. Goodman</i> 180
EPILEPSY AS A SCHOOL HEALTH PROBLEM.....	<i>M. E. Hawkins</i> 182
NURSES CAN INFLUENCE THINKING.....	<i>M. W. Smith</i> 184
ACCREDITATION OF EDUCATIONAL PROGRAMS IN NURSING.....	<i>M. M. Street</i> 187
NURSING PROFILES.....	190
ANILINE DYE POISONING OF BABIES.....	<i>H. C. Howes</i> 194
ESOPHAGECTOMY AND GASTRO-ESOPHAGOSTOMY.....	<i>N. Cosh</i> 197
THE UNIVERSITY'S PART IN PLANNING A STUDENT PROGRAM.....	<i>J. M. Weir</i> 201
ASSURANCES SOCIALES.....	<i>S. Giroux</i> 204
TRENDS IN NURSING.....	207
ORIENTATION ET TENDANCES EN NURSING.....	209
WORK CONFERENCES.....	211
ANNUAL MEETING IN NEW BRUNSWICK.....	<i>A. F. Law</i> 214
WHAT I HAVE LEARNED ABOUT NURSING.....	<i>S. Smith</i> 216
WHAT I THINK ABOUT NURSING.....	<i>J. Harrington</i> 218
MRS. JONES HAD ENOUGH.....	<i>D. Deane</i> 219
NURSING IN OSLER'S STUDENT DAYS.....	<i>H. E. MacDermot, M.D.</i> 222
BOOK REVIEWS.....	224
NEWS NOTES.....	227
OFFICIAL DIRECTORY.....	240

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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up to

times greater absorption
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Clinical tests indicate that when Vitamin A is given in a water-dispersible rather than an oily vehicle, up to five times greater absorption takes place. Similarly storage of both Vitamins A and D is also greatly increased and excretion is less.

"ALPHAMETTE" Aqueous No. 929

Each drop contains approximately:
Vitamin A 1,000 I.U.
Vitamin D 500 I.U.
The suggested daily dose is 2 drops.
In bottles of 8, 15 and 30 cc. with dropper.

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The average daily dose of 10 drops
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Vitamin D 1,000 I.U.
Ascorbic Acid 50.0 mg.
Thiamine 1.5 mg.
Riboflavin 1.0 mg.
Niacinamide 20.0 mg.
Pyridoxine 1.0 mg.
Calcium d-Pantothenate... 5.0 mg.
Mixed Natural Tocopherols
(as Antioxidant) 2.0 mg.
In bottles of 8, 15 and 30 cc. with dropper.



Ayerst, McKenna & Harrison Limited

Biological and Pharmaceutical Chemists • MONTREAL, CANADA

Between Ourselves

There is an old saying—attributed to Confucius—to the effect that “a journey of a thousand miles begins with the first step.” With Vancouver on the “outskirts of Canada,” as a tourist from another country once phrased it, most nurses who will be attending the **C.N.A. Convention** there in June will have many hundreds and thousands of miles to travel. There are several “first steps” that should be taken to ensure a profitable experience at the convention and the maximum of pleasure from all the new sights and scenes. Since it is anticipated that this may prove to be the largest nurses’ convention ever held in Canada from the standpoint of registration, some careful planning right now may save a lot of fussing later.

As an initial step, we suggest that all of you who have definitely decided to go to Vancouver should make a point of getting your **Registration Form** from your own provincial nursing office immediately. When you have completed it, send it and the registration fee to National Office right away or at least on your next pay-day. A receipt will be returned to you which will entitle you to your full quota of materials at the registration counters at the convention.

After you have signified your preference in regard to lodging during the convention, give some thought to your choice of **Work Conferences**. Marion Nash, assistant secretary at National Office, has been editing a special section on these in each issue since December. Space is also provided for you to signify your preference in work conferences on the registration form.

If this is your first trip to the far west, there will be dozens of spots you will want to visit. Do some careful planning in this matter, too, so that you will be able to see the most in the time and money at your disposal. Watch for the special articles on British Columbia and Vancouver coming in our *April* and *June* issues. The **Special Convention Issue**, containing all the major reports, will be published in *May*. You will want that copy with you at the convention

so watch for it and preserve it carefully. We will be printing extra copies which can be ordered in advance at the regular price of 25 cents per copy, if you do not wish to take your one and only copy with you. Send your orders directly to the *Journal* office—*Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.* Be sure to specify the May issue when ordering.

* * *

Our guest editor this month, **Maisie K. Miller**, president of the Registered Nurses’ Association of Nova Scotia, is well known to nurses all over Canada. A native of New Brunswick, she graduated from the Moncton Hospital. In 1937 she was awarded the Florence Nightingale Memorial Scholarship by the C.N.A. and enrolled for courses in hospital and school of nursing administration at Bedford College, London. Miss Miller has had varied experience, including two years as assistant to the executive secretary of the C.N.A. She has been superintendent of nurses at the Victoria General Hospital, Halifax, for the past five years.

* * *

Our favorite medical dictionary defines **epilepsy** as: “A disorder of the central nervous system; characterized by recurring explosive nerve cell discharges and manifested by transient episodes of unconsciousness or psychic dysfunction, with or without convulsive movements. The discharge or seizure is associated with a pronounced change in the electric activity of the brain cells, and the normal synchrony is distributed by a dysrhythmia.” We will agree that few of those words would appear in a dictionary of basic English. However, Dr. Gould’s explanation will clarify any of the obscure points. Col. Goodman’s death was reported in mid-January. Miss Hawkins explains how this particular series originated.

* * *

Canada can be justly proud of her part in the production of the fine new film depicting **cancer research and treatment** which is to have its New York première this month. We are indebted to Col. C. W. Gilchrist, director of Information Services for the Department of National Health and Welfare, for the advance story.

WHEN MASSIVE SALICYLATE THERAPY IS INDICATED...

toxic effects, such as depression of blood prothrombin and hemorrhagic tendency, are avoided by the administration of

BEREX—*the NON-TOXIC product of choice*

because it provides, in tablet form, an easily administered and scientifically-balanced combination of calcium succinate and acetylsalicylic acid.

Full details concerning BEREX in the treatment of acute and chronic rheumatism, with extensive bibliography, available on request.

Available in bottles of 100 and 500 tablets.

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BEREX Pharmaceutical Co. • 36-48 Caledonia Road • Toronto, Canada

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

PARADIONE

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each red capsule contains 0.3 gm. of Paramethadione, Abbott (3,5-dimethyl-5-ethyloxazolidine-2, 4-dione).

Indications—Petit mal, myoclonic and akinetic epilepsy. Effective in certain patients in whom Trimedone has not been of benefit and vice versa. Contraindicated in patients with renal or hepatic disorders.

THENYLENE HYDROCHLORIDE CREAM

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Contains 2% of Thenylene Hydrochloride (n,N-dimethyl-N'-(alpha-pyridyl)-N'-(alpha-ethylene-diamine hydrochloride, Abbott) in a water-soluble base.

Indications—For tropical application in itching dermatitis where an allergic factor is involved. May be used for symptomatic relief as a supplement to oral treatment with Thenylene Hydrochloride, especially when skin lesions are extensive and systemic allergic manifestations are present.

CORAMINE-ADENOSINE

Manufacturer—Ciba Company Limited, Montreal.

Description—Each cc. of liquid contains: Coramine 200 mg., Theophylline 75 mg., Adenosine 1 mg.

Indications—Angina pectoris, cardiac asthma, hypertension, Cheyne-Stokes syndrome, coronary insufficiency, etc.

Administration— $\frac{1}{2}$ to 1 cc. (10-20 drops), two or three times a day, preferably after meals.

CORAMINE-GLUCOSE

Manufacturer—Ciba Company Limited, Montreal.

Description—Each tablet contains: Coramine 125 mg., Glucose 1.5 gm.

Indications—Fatigue, air sickness and to overcome weakness during convalescence and old age.

Administration—One tablet every $\frac{1}{2}$ to 1 hour, dissolved slowly in the mouth. Daily dose may be from 4 to 6 or even 8 tablets.

COBENZIL

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each fluid ounce represents:

Codeine Phosphate	1 gr.
Sodium Citrate	25 gr.
Ammonium Chloride	5 gr.
Ipecac Syrup	30 min.
Menthol and Aromatics	q.s.
in a benzoinated syrup, pleasantly flavored.	

Indications—Coughs due to colds and other upper respiratory infections.

Administration—Adults, 1 to 3 teaspoonfuls every 2 to 4 hours as needed. Children over one year, $\frac{1}{2}$ to 1 teaspoonful according to age. Infants one month old, 2 to 3 drops; three months, 4 to 6 drops; six months, 6 to 10 drops. Doses for infants and children should be given not oftener than every four hours.



Valuable for
COMPRESSION AND SUPPORT
Elastocrepe
TRADE MARK

SMOOTH SURFACE CREPE BANDAGE

Elastocrepe is Elastoplast cloth without the adhesive spread. It therefore, has the unique properties of stretch and regain which are associated with Elastoplast.

Elastocrepe provides comfortable and adequate support and compression for its particular purpose, and is superior in every way to the ordinary crepe bandage. When soiled it may be washed—washing renews its elasticity.

SMITH & NEPHEW LIMITED
378 ST. PAUL ST. W. — MONTREAL

ORTHOXICOL

Manufacturer—The Upjohn Company, Toronto.

Description—Each fluid ounce of syrup contains: Dihydrocodeinone Bitartrate 1/6 gr., Orthoxine (methoxyphenamine Upjohn) Hydrochloride 1½ gr., Hyoscyamine Hydrobromide 1/100 gr., Sodium Citrate 30 gr.

Indications—Conditions where a bronchodilator, sedative cough syrup may be indicated.

Administration—Adults, 1 to 2 teaspoonfuls every 3 or 4 hours as required. Children, ¼ to 1 teaspoonful every 4 hours as required. Subject to narcotic regulations.

NEO-ANTERGAN SUPPOSITORIES

Manufacturer—Poulenc Laboratory Limited, Montreal.

Description—Acid maleate of N-dimethylaminoethyl-N-paramethoxybenzyl-d-acinopyridine in suppository form. Ideal treatment where Neo-Antergan is not tolerated by oral administration.

Indications—Seasickness—vomiting in pregnancy.

Administration—1 to 3 suppositories as directed by the physician.

GANTRISIN 'ROCHE'

Manufacturer—Hoffmann-La Roche Limited, Montreal.

Description—A new sulfonamide, 3, 4-dimethyl-5-sulfanilamido-isoxazole, characterized by high solubility. The use of Gantrisin is unlikely to cause crystalluria and deposition of crystals in the urinary tract.

Indications—Gantrisin is recommended for systemic infections due to streptococci, staphylococci, pneumococci, and meningococci, and for urinary tract infections, especially when due to *B. coli*, *B. proteus*, and *B. pyocyaneus*.

NEMBUTAL SODIUM SOLUTION

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each cc. contains Nembutal Sodium (Pentobarbital Sodium, Abbott) 50 mg., Propylene Glycol 20%, Alcohol 10%, in Water for Injection, U.S.P.

Indications—For controlled pre-operative sedation or basal anesthesia; for obstetrical amnesia and analgesia; for control of acute maniacal states; and control of convulsions in tetanus, eclampsia, etc.

Administration—Adults: Inject slowly intravenously at a rate not exceeding 1 cc. per minute until the desired degree of sedation is attained. Single adult dose at one injection should not exceed 5 cc. Smaller doses may be repeated as necessary.

"PYRITHEN" COMPOUND

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Compressed tablets containing:

Pyrithen (brand of chlorothen citrate).....	25 mg.
Acetophen (brand of acetylsalicylic acid).....	200 mg.
Phenacetin.....	150 mg.
Caffeine.....	30 mg.

Indications—For relief of symptoms of the common cold, headaches, and allergic manifestations, one tablet every four hours for 8 to 12 doses. Treatment is most effective when started at the very onset of symptoms.

A serious problem in public health is the fact that the number of diabetics is increasing and that a great many people have diabetes and are not aware of it. It

has been estimated that for every four known cases there are three that are not diagnosed or suspected. The prevalence of diabetes is highest among older people.



THE NEW
ANTI-NAUSEANT

Gravol

for
**PREGNANCY
MOTION SICKNESS
RADIATION SICKNESS**
And other conditions where
nausea and vomiting
are factors

Reports from the literature on beta
dimethylaminoethyl benzohydryl
ether 8-chlorotheophyllinate
(GRAVOL)

GRAVOL IN PREGNANCY

"Out of forty-three women with
symptoms from 4-6 weeks, thirty-
one (72%) were completely re-
lieved within 3 hours after treat-
ment. Twelve women (28%) had
no relief." (1)

GRAVOL IN MOTION SICKNESS

98.6% effective in prevention of
sea sickness . . . eliminates symp-
toms in up to 97.6% of cases
already developed. (2)

GRAVOL IN RADIATION SICKNESS

Out of 82 patients with moderate
to severe radiation sickness, 65
reported good to excellent relief.
(3)

FORMULA OF GRAVOL: Each
scored tablet contains: Beta di-
methylaminoethyl benzohydryl
ether 8-chlorotheophyllinate. . . .
50 mg.

PACKAGE: Available in vials of
25 and 100 scored 50 mg. tablets.

NOTE:—To date there is no evidence of toxic reactions with
Gravol. However, some individuals may become drowsy or
confused on high or continuous dosage.

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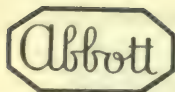
CANADA



THE VITAMIN HOUR

.... can be like this!

When the Vi-Daylin bottle is opened, children come running. They smell this honey-like liquid, taste the lemon-candy flavor, and are quick to take the prescribed dose—no coaxing, no coyness here. One teaspoonful a day is the average dose for children up to twelve years old. Vi-Daylin is ideal for babies too, as it's easy to mix with formula, fruit juice or cereal. Contains practically no alcohol—less than 0.5%. For mothers there's an extra bonus—Vi-Daylin has no fishy odor, stays fresh without refrigeration. The formula shows its potency, the Abbott label assures you of its purity and stability. Vi-Daylin is obtainable in two convenient sizes: 90-cc. and 8-fluid-ounce. ABBOTT LABORATORIES, LIMITED, MONTREAL.



Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	5000 Int. units
Vitamin D	1000 Int. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Nicotinamide	10 mg.

SPECIFY

Vi-Daylin
TRADE MARK

(HOMOGENIZED MIXTURE OF VITAMINS A,
D, B₁, B₂, C AND NICOTINAMIDE, ABBOTT)



The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION
VOLUME FORTY-SIX
NUMBER THREE

MONTREAL, MARCH, 1950

Great Expectations

Average reading time — 5 min. 36 sec.

THERE ARE few pleasures which are not mixed with some pain or disappointments. In writing about the developments in nursing in Nova Scotia during the past two years, I must include those things which have given us, in some instances, a feeling of failure.

Although it was with keen satisfaction that nurses in all provinces heard that the Federal Government was making large grants of money to improve the health services throughout Canada, it soon became apparent to us that nursing was not being given the place we had hoped in the over-all plan. We had long been aware that in no way could the supply of nurses meet the demand—not that the supply had diminished but because the demand for qualified nurses had increased.

The immediate plan in all provinces seemed to be to add wings to hospitals already in use, and to build new ones, but no suitable provision was made for staffing them, either with qualified nurses or students. Residences were filled to overflowing and teaching departments in most schools of nursing were quite inadequate both as to space and personnel.

In Nova Scotia, as in other pro-

vinces, a brief was presented by the Registered Nurses' Association to the provincial government, asking that consideration be given to nursing needs, the most pressing of which was a survey of nurses already available in the province, and the number which would be necessary in the future expansion of hospital and public health services. A partial survey has been made but this is not a complete record of nurses in all



R. Norwood, Halifax

MAISIE K. MILLER

categories throughout the province. We have recently been advised by the director of the Survey Committee that an effort will be made to secure the services of a qualified nurse to carry on a systematic survey during the coming months. It is hoped that when this has been completed we shall be in a better position to evaluate both our present resources and our needs for the future.

We were gratified that our association was asked to name a representative to the provincial Survey Committee. While we have been disappointed that so far most of the sum of money allocated for the training of nurse personnel has been granted to public health nurses who will return to governmental positions, we are optimistic that the need will be recognized for the additional training of nurses for both voluntary public health organizations and for hospitals. While we are well aware that nurses are needed everywhere, all recognize the fact that it is in the schools of nursing that nurses, who will later assume responsible positions, receive their basic training. It is in these hospitals that we have not the qualified graduates to teach the basic subjects both in the classroom and the wards. Already some of our qualified instructors have resigned from hospital positions to enter the field of public health.

A request was made for financial assistance to secure a school of nursing adviser. A similar request was made to their respective governments by New Brunswick and Prince Edward Island. It was thought that, with such assistance, it would be possible to secure a well-qualified nurse to visit schools of nursing in the three Maritime provinces, in order to improve student education by standardizing the curriculum and by the introduction of qualifying examinations at the end of the first year. The request has been granted in New Brunswick and Prince Edward Island, but up to the present time the Advisory Committee in Nova Scotia has not approved the expenditure of any part of the Dominion-Provincial

funds for this purpose. Though this has been a disappointment to us we are pleased that the other two provincial associations will be able to proceed with plans for a school of nursing adviser. We hope that a later request to our committee will be granted.

In this province, as elsewhere, it is recognized that sooner or later there must be two groups of nurses—the registered nurse and the nursing assistant—if nursing needs are to be met. Unfortunately, the public was not as aware of the need for some control of the assistant nurse as was our association! In 1948, the Bill, which we presented to the provincial Legislature and which would have licensed the assistant group and given recognition to it, was not accepted. Members of our association were keenly disappointed. Since that time the Legislative Committee, with the assistance of the several branches in the province, has drawn up amendments to our present Constitution for the Registered Nurse, which are being presented to the Legislature this year.

The construction by the Provincial Government of a new nurses' residence for a general hospital and a sanatorium is underway at present. We have hopes that assistance will soon be forthcoming from federal funds so that similar construction may be carried out in non-governmental schools of nursing.

It has been a great satisfaction that a post-graduate course in public health nursing has been established at Dalhousie University. We look forward to the inclusion of a course in teaching and supervision in the autumn of 1950.

We have been advised that Dalhousie University has also established a combined course leading to the degree of Bachelor of Science in Nursing. This includes three years of study at the university and 30 months of practice in a hospital. Provision has been made in the revision of our Act for the registration of those who complete the course and who pass the examinations set by the association.

It is hoped that one or more re-

fresher courses in ward teaching and supervision will be given in the near future. Many recent graduates are holding ward positions for which they have had very little, if any, preparation.

In any organization where the services of the members are voluntary, and apart from the positions held by them, we must rely on the willingness of their employers to release them to attend meetings and also of the individuals themselves to travel considerable distances in order to discuss

problems and to make plans for solving them. Organizations and members of our association have always been most co-operative. I feel sure that they are aware that it is only by the united effort on the part of nurses themselves and the public that adequate nursing service will be within reach of all who need it.

MAISIE K. MILLER
*President
Registered Nurses' Association
of Nova Scotia*

Cancer Research in Pictures

LAURENCE ST. MAURICE

Average reading time — 5 min. 36 sec.

Note: The notables in the world of health who attended the world première of this film in New York, among them representatives from the governments of the U.S.A. and Canada and the World Health Organization, were aware that, apart from the normal importance and interest of the occasion, it was significant in another sense. It marked the first time that two governments have joined forces to make a film in the field of health.

Early last year, U.S. public health authorities learned that Canada's Department of National Health and Welfare had commissioned the Canadian National Film Board to make a film on cancer research. They approached the department with every evidence of interest; it seemed that for some time they had had just such a project in mind. The result was an agreement between Canada's Department of National Health and Welfare and the National Cancer Institute of the U.S. Public Health Service to pool their resources to make a bigger and better film than either could have undertaken alone.

All production matters were left entirely in Canadian hands. It may be properly regarded as a mark of esteem that the U.S. representatives asked that the film be made by the Canadian National Film Board.

A Canadian première in Ottawa, after the New York showing, will be followed, as part of the opening guns of the April Cancer Campaign, by previews in the capitals of all the provinces. These latter will be arranged under the auspices of the provincial branches of the Canadian Cancer Society.

Further, the French version of the film will be sent to the International Cancer Conference which is being held this summer in Paris. As regards its usefulness abroad, U.S. authorities are at present considering putting it into more than a dozen foreign languages.

THE NURSES regarded each other somewhat doubtfully. The uni-



The hospital waiting-room



The cameras lined up

forms they were wearing were certainly not the ones used at this particular hospital. More unsettling still, the color was a most unprofessional greenish yellow. Then the glaring flood-lights came on, the camera started to turn, and all at once they were acting out their parts, forgetting to worry about whether it was true, as the director had told them, that on the screen the uniforms would look white. They were much too busy helping to make the film, "Challenge: Science Against Cancer," whose world première in New York this month was timed to lead off the April Cancer Campaign.

This three-reel, half-hour, black and white film (in 16 as well as 35 mm. versions) was made to tell a general, non-technical audience what the research scientists are doing about cancer; how they are going about the business of finding the cause and cure of a disease which ranks second on this continent as a killer, and first as a source of fear.



Using the Geiger counter on patient with radio-active isotopes



The close-up scene

In many a hospital and laboratory in both the U.S. and Canada, nurses, technicians, doctors, and scientists, who had never before appeared before the business end of a camera, found themselves donning the specially-dyed garments to add their particular specialty to the total story of the film.

Everyone agreed that the policy of complete anonymity that was laid down was the only one that could be followed in a field of research where there were so many divergent points of view, and where so many were making valuable contributions.

Everywhere the fullest co-operation was extended to the film crews. This statement will carry special weight for those who realize what can happen



Examining both normal and cancerous tissue

to complicated routines and schedules when a movie crew moves in for a few days with several tons of equipment and a new set of problems.

The film owes a great deal to the active assistance of institutions in Canada like the Toronto General Hospital, the Connaught Laboratories, the Banting and Best Institute, and various departments of the University of Toronto; and in the U.S.A., the Atomic Energy Project and the Strong Memorial Hospital, both in Rochester, New York.

Very early in the planning of the film it was decided to deal only with the research side of the fight against cancer, since, unlike the subjects of treatment and diagnosis, this aspect had never been adequately reviewed before in any filmic report to the public.

The story opens in a hospital waiting-room on a note of hope; the facilities of modern research, whose past successes have enabled us to do something for these waiting patients, are now concentrating on the problem of cancer.

An imaginative tour—in animation—through the organs and tissues of the living body presents the problem: cancer is uncontrolled growth. The magnitude of the task which confronts the scientist becomes clearer. To understand the cancer process he must explore the inner workings of the single, living cell—a structure less than two-thousandths of an inch in size, which yet contains complexities that would put a whole chemical industry to shame.

The production of this sequence required the National Film Board to develop some completely new animation techniques. The Animation Department completed more than 2,000 detailed anatomical drawings, not to mention preliminary sketches and discarded experimental material. The technical accuracy of the drawings was supervised by a specialist in medical animation brought to the National Film Board from the Medical Film Institute of the Association of American Medical Colleges.

The film then conducts the au-



Implanting tumor growth in eggs

dience through some of the laboratories where the work goes on. In a field where almost every major branch of science is contributing, it was possible only to indicate a few of the many approaches to the problem.

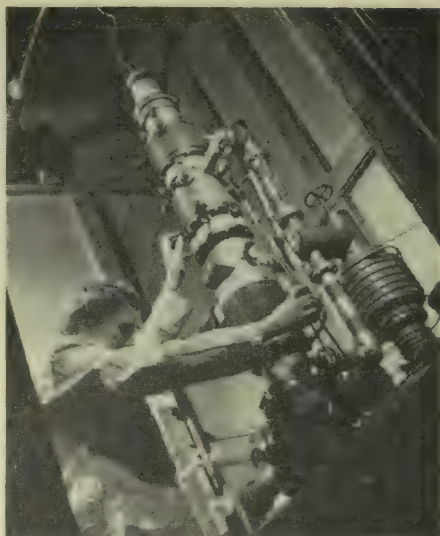
In one laboratory living cancer tissue is being grown and studied in glass containers. In another, mice have been interbred, in brother to sister matings, for more than 20 generations, to try and separate effects due to heredity from those due to environment. Statistics machines help sort and compile vast quanti-



Using the ordinary microscope



The radon emanation plant



The electron microscope

ties of seemingly unrelated facts—some of them may provide a clue. Then in the laboratory of the chemist a substance known to be a cancer agent is being analyzed—one, perhaps, at which statistics had pointed the finger of suspicion.

In addition to the fundamental, long-range research projects, the film shows something of that work which is more immediately applicable to alleviate human suffering. Already the use of the new radio-active isotopes, of hormones, antibiotics, and high energy radiation machines has made available the techniques which were impossible even a few short years ago.

The truly international character of cancer research is emphasized everywhere throughout the film. The published findings of a scientist in France or Sweden may provide the

clue necessary for a discovery of major importance in some laboratory in Canada.

In addition to informing the public in general it is hoped the film will interest those young people who are entering the colleges and universities. If it can arouse in them a desire to enter the field of scientific research in general, some, at least, will end up among those who are seeking to wipe out cancer.

In its conclusion the film holds out no false hope that the solution to the cancer problem lies just around the corner. There is hope, but it lies only in the unremitting efforts of the scientist. That is the message of the film—that the work of research must not go on in isolation; that it merits our understanding, our sympathy, and our active support.

Calcium in Pregnancy

Nutritionists agree that the diet of expectant mothers should be rich in the basic elements, especially proteins, calcium, phosphorus, and vitamins. Numerous studies have proved that, especially during the later months of pregnancy, the requirement and retention of calcium increase considerably. During pregnancy the estimated daily calcium requirement is 1.5 to 3 grams and the total retention is about 50 grams. If the mother is not getting

sufficient calcium to meet the requirements of the fetus, calcium and phosphorus are withdrawn from the maternal skeleton with consequent demineralization of the latter. The onset of lactation is marked by a sudden change from positive to negative calcium metabolism. This loss of calcium may be diminished by increasing the daily amounts of vitamin D.

Diagnosis and Treatment of Epilepsy

C. E. GOULD, B.A., M.D., L.M.C.C.

Average reading time — 12 min. 12 sec.

A condition which has received relatively little attention from the public health field up to the present time is epilepsy. The Health and Auxiliary Division of the Community Chest and Council, with the Health and Welfare Education Group of Vancouver, decided

to hold an institute centring around this topic. Leaders in all the fields relating to either the study or treatment of the disease were invited to participate in a panel discussion. It was felt that it would be of interest to bring to the nurses of Canada some of the papers.

EPILEPSY CAN BE defined, primarily, as a discharging lesion occurring in the brain actually based on an electrical discharge which produces a disorder which may be on a physical and/or psychological plane. To make that more plain, the epileptic has a type of cerebral dysrhythmia which may be disclosed by the electroencephalograph. A normal person has a normal pattern of brain wave for various conditions. When his mind is active there is one pattern; when he sleeps there is another. The average pattern for the average individual is fairly well worked out. The epileptic has an abnormality in the rhythm of his brain waves which may only manifest itself at certain times. A fit or seizure is the result of the abnormality of these brain waves, which represents, as nearly as we can tell, an electrical discharge which may have started in any portion of the brain, has swept various portions of it, and produces the various typical manifestations.

Depending upon the portion of the brain in which this unusual discharge takes place are the clinical manifestations of epilepsy. There are four clinical types: grand mal, the major fit; petit mal, the minor fit; psychomotor epilepsy; and symptomatic epilepsy or Jacksonian epilepsy. The latter comes from a discrete lesion of the brain, scar tissue, or tumor. It

is organic and in many cases the surgeon can remove it. It is really not a type of epilepsy but a clinical entity.

The most dramatic form, the grand mal, is a convulsion, and is the popular conception of epilepsy. One only has to see it to be able to recognize it again. It is usually preceded by some warning to the patient and starts off, sometimes, with a spasm of the glottis which produces a bark or cry. This is followed by a loss of consciousness. The patient falls to the ground and a convulsive shaking takes place which is usually manifested by the so-called tonic beginning, which is a position of complete spasticity. The eyes may roll back and the lids close, while the legs are extended. Then the convulsion starts—the clonic or intermediate phase—with a shaking of the extended extremities. It is over in a minute or a minute and a half. Shortly after the patient becomes conscious and then may drop off into a sleep which may last for two or three hours. He will waken feeling stiff, fatigued, and with a headache. That is a typical episode of grand mal.

The first aid treatment to give a person in a seizure is simple. Ordinarily the patient falls to the ground and is in the clonic stage of the convulsion. If he has struck something or is leaning up against an object, complications may follow. The only danger is that he may cut his lips or tongue with his own teeth. The thing to do is to get a gag in his mouth. This is impossible in the tonic phase, but once he starts

Dr. Gould is a neuropsychiatrist at the Vancouver General and Shaughnessy Hospitals.

the clonic phase it is quite easy. Twist your handkerchief (forgetting all your bacteriology for once!) and put it between the teeth. These patients often turn a dusky hue but they never die of a convulsion. Loosen the tie, unbutton the collar, and that is about all you can do. The less fuss and bother the better. Do not try to restrain the patient's movements. Let him have his fit out, save the tongue from getting bitten, and treat the on-lookers.

Petit mal is something entirely different. People usually do not recognize it as epilepsy. The patient often describes it as a little vague spell, or just as if a curtain had dropped before his eyes. It is on and off again in a fraction of a second. Frequently a person talking to the patient at the time may just think he lost the word he was looking for. Sometimes a blank expression comes over the face. These attacks present almost no disability to the patient other than the worry they cause him. As a feature in employment, petit mal would be almost of no significance.

The third variation is the interesting one and that is the one about which we are learning more and more, particularly with the aid of the electroencephalograph. This is psychomotor epilepsy. Here, there is an electrical discharge leading to an attack, which we know now as an attack of epilepsy, but which manifests itself ordinarily in unusual behavior. Frequently it follows a set pattern, that is, each attack follows the same psychomotor pattern. There can be any number of variations to them. There are many interesting, funny, pathetic manifestations of psychomotor epilepsy. One case was a girl in whom the entire manifestation of her attacks was that, when walking along the street, she would stop and, pointing to the sky, say, "Praise God!" Then, pointing to the ground, she would say, "Down to the Devil!" That was the complete attack and it repeated itself time after time.

Another pattern was in a young woman who was sitting one day in

her kitchen with a very young baby on her lap. She felt a tingling sensation upon one side of her body, and as it passed over the top of her head she was possessed with an insatiable desire to pick up the butcher knife, which was lying nearby, and stab the baby with it. The tingling sensation passed down the other side of her body and she returned to normal. But this attack occurred three times, each time in her own home with nobody around. A diagnosis of psychomotor epilepsy was made. She was put under appropriate treatment and had no further attacks.

More significant are the pathological types which manifest themselves in extremely peculiar behavior. These have become issues in the courts of law, as you might expect. Crimes or psychopathic behavior repeated over and over again can sometimes be demonstrated to be something which is in fact beyond the control of the patient, in so far as it is associated with some type of abnormal discharge in the brain. The patient has no control over his behavior or over the crime he committed.

Epileptic seizures can commence at a very early age—four or five is not uncommon. There are two schools of thought about the occurrence of convulsions in infants. There is evidence to suggest that when an infant has convulsions from an obvious cause, such as teething, fever, etc., it shows, in fact, a tendency towards epilepsy. The great majority of seizures, however, have their onset between the ages of 10 and 20. Of the remaining cases, 75 per cent have their onset in the third decade.

It is not known whether or not a child who has a convulsion at six months, brought on by a high temperature, would be liable to epilepsy in later years. There is no need to develop an anxiety state over any infant that has convulsions, on the assumption that it is going to become epileptic, because most frequently it does not. Probably the answer may lie in the fact that we have never been able to get sufficient series of encephalographs of infantile

convulsions to say whether they have an epileptiform pattern. A large number of epileptic adults have never had convulsions as infants, and a great many infants who have had convulsions have never developed epilepsy.

In both diagnosis and treatment, the electroencephalograph represents by far the greatest recent advance. While it gives a certain amount of information now, it is probably in the same stage of infancy as some other machines, which are far more accurate now than they were when first introduced, say, 20 years ago. Its practical use dates back only a few years.

The drugs used most frequently in treatment are phenobarbital and dilantin. Recent developments include tridione and mesantoin. It should be stressed that, from a practical, clinical standpoint, it is important to make use of the treatment available. We have, to a remarkable degree, the ability to control epilepsy, providing we have the necessary factors which really make the treatment come into play, and providing that the patient does not break the rules. There are three important *don'ts* that are given to epileptics:

1. Don't drink alcoholic beverages.
2. Don't overdo, particularly when it results in loss of sleep.
3. Don't slip up on taking your medicine. This last is really the most important.

The random seizure that occurs every month or six weeks is generally the result of a patient missing a dose or two of his medicine. We find that is usually the cause of fits in patients who have been given what seems to be an adequate schedule of dosage. How to avoid these lapses is a great problem. So many psychological considerations enter into epilepsy. Whose aid are you going to recruit, in addition to the patient, to make sure that he takes his medicine regularly? It is often a matter of considerable acumen to decide whether to enlist anybody's aid at all. One wonders whether to put an adolescent under the care of

his parents, or to put him on his own and appeal to his reliability. The most important thing is to make sure that the dosage is taken with unflinching regularity. The hue and cry to have various new drugs tried out is of no avail unless the patient co-operates.

Phenobarbital and dilantin are both extremely potent anti-epileptic medicines. The question of amount is important. It takes months to adjust the patient. It is necessary to get him to the point where he is taking enough and just a bit more. That may involve six dilantin tablets, of a grain and a half, a day. That may seem a lot but many people tolerate six with very little difficulty. Complications with dilantin are rare. The commonest represents a sponginess or softening of the gums, which can be dealt with, and which certainly is negligible compared to the fits themselves. The occasional development of dizziness or some gait difficulty is quite rare.

One has to feel his way to obtain the optimum dosage of phenobarbital. Two half-grain tablets may be enough for a 250-pound logger, while a woman weighing 95 pounds may tolerate six half-grain tablets. Everybody has his individual tolerance to phenobarbital, and the doctor can only find this by increasing the dose gradually until he gets the patient a little drowsy. Then he cuts that dosage down until he finds the correct amount.

In severe epilepsy, the use of two or sometimes three drugs seems to have a synergistic effect—that is, one is complementary to the other. Sometimes, when the patient is on a sedative drug such as phenobarbital or mebaral, one can also use benzedrine to offset the effect of drowsiness.

Diet plays a part in the treatment of epilepsy only as a last resort. The use of ketogenic diets, or any other type of dehydrating diet, is sometimes tried, but only after one has become fully convinced that drug treatment is not helpful. Such a case is a very serious problem, for the patient would not be in a condition to undertake a complicated diet.

The cost of medication to the

epileptic is not too great a problem. The average patient gets phenobarbital or dilantin. These drugs take care of 75 per cent of epileptics. The usual dosage requires approximately one and one-half grains of phenobarbital per day, at a cost of \$1.00 a month. With dilantin, the average dose is four tablets per day. This will cost him approximately \$3.00 a month or a total of \$4.00 per month. The patient must see the doctor perhaps once a month or, if the treatment is well established, once in three months. Adding on the physician's fee brings the total to \$7.00 per month. With a patient who is using more dilantin or benzedrine it can run to \$12.00 or \$15.00 a month. Some patients can get along very well on phenobarbital alone, with one visit to the doctor

a month. The total cost of treatment runs from a low of \$3.00 to a high of \$15.00 a month.

We should not be dazzled by new drugs on the market. We want to use the ones we have and see that our patients adhere to their treatment. The next thing is alcohol. We are not getting anywhere with an epileptic until he gets on the wagon and stays there. The third rule is the leading of a regular life. If an epileptic stays up late and has only a few hours of sleep, he may have a fit within a day or two.

To sum up, the encephalograph represents a tremendous advance in diagnosis. Phenobarbital and dilantin are our main drugs. Mesantoin and tridione are so recent that nobody knows what their potentialities are.

Employment of the Epileptic

The late H. E. GOODMAN

Average reading time — 6 min. 24 sec.

BEFORE STARTING on a discussion of the problems encountered in the placement in employment of the epileptic, it will be necessary to briefly outline the methods used by the Special Placements Branch of the National Employment Service in finding employment for the "occupationally handicapped" citizens. You will note that I specify the term "occupationally handicapped," as not every physically disabled person needs assistance in finding employment. The group who do need our help are those unfortunate persons who, because of some physical or mental disability, are unable to locate suitable employment without specialized assistance.

The methods used are comparatively simple and depend very largely

on the detailed knowledge that can be gained of the individual's remaining physical and mental powers, his training, education, past experience, etc. In addition to this, we have to ascertain the conditions under which the applicant can work with safety to himself and his fellow workers. This, when compared with the actual requirements of specific occupations, enables us to literally fit a man or woman to a job. In the great majority of cases, this results in the beginning of a new life for the disabled person and a satisfactory employee for the employer.

Using this system, the first information we must obtain from the applicant is "what can you do?" and "under what conditions?" This, in the case of the majority of epileptics who are not undergoing treatment, is a most difficult task as, frequently, they are either unable or unwilling to give the required information.

Until a short while ago, people

The late Colonel Goodman was supervisor of Special Placements, National Employment Service, British Columbia, for many years.

were almost afraid of even the word "epilepsy." More recently, we have felt there are grounds for hope that there are answers to their problems and it is for the purpose of obtaining and disseminating this information that this paper originated.

The epileptic problem is a puzzling one in many ways. We know that many interesting recruits for the armed forces were rejected and that large numbers were later discharged as their conditions became apparent, yet we run into comparatively few of them in our work. Despite this, they constitute one of our most difficult problems. Undoubtedly many are placed in employment without their disability being known to either the placement officer or the employer and are able to carry on their work without undue difficulty. These, of course, include those who have their disability under control through proper treatment.

Unfortunately, many of those who apply to Special Placements for assistance have never had either the opportunity or the financial resources to obtain skilled treatment. Consequently, they have only the vaguest knowledge of their own condition and capabilities. Often their mixed aggressive and defensive attitude militates greatly against their chances of finding employment. Many of them seem to feel that they are in a class set aside from the rest of the world and that everybody is against them. They appear to have built up inferiority and defensive complexes, and one can see from talking to some of them that they feel they have been driven to concealment and secrecy.

It is strange that so many epileptics know so very little of their own affliction. When we enquire even regarding the frequency and duration of the seizures, we often get the vaguest of answers. In the case of younger applicants, it is frequently equally difficult to get authentic information from the parents, who feel that there is something shameful about the disease, something to be concealed.

I, personally, had the idea that

epilepsy was one of those dread diseases that are incurable and had considered the majority of epileptics to be unemployable, until one day I read an article in the *Saturday Evening Post* entitled "We Can Lick Epilepsy." It told of the research work of Dr. Lennox, who had developed the use of some new drugs—dilantin, tridione, and mesantoin—which, the article claimed, were being used successfully to control seizures. The statement that stuck in my mind, and which impressed me mightily, was that, under proper treatment, 80 per cent of epileptics were capable of sustained employment.

Presuming that such treatment is available and is successful, we are still up against a very serious obstacle from the viewpoint of the average employer, who refuses automatically to employ epileptics. They do, of course, occasionally employ them unknowingly, sometimes under conditions disadvantageous to both parties. Many employers have the fixed idea that epileptics are persons with inferior personalities, characteristically feeble-minded, who may lapse into violent convulsions at any time without warning. They consider the epileptic to be defective in mind, body, and personality and fear that he will find the stress of sustained effort of any kind entirely impossible.

In addition to this, the employer is concerned with the loss of working time through seizures and the effect on their other employees. Most people do not like to work beside an epileptic, as they dislike viewing anything as unpleasant as a violent convulsion. Even after providing employment, the employer quite often weakens after the first seizure takes place, as he can see no good reason why he should be called upon to act the Good Samaritan.

Until recently, when we became better informed on this subject, the epileptic was forced to conceal his affliction in order to have any chance of employment. Even now, those who voluntarily divulge their condition are in the minority. If we could get the same type of favorable publicity

regarding the employment of the handicapped of all types as is current in the United States, it would help a great deal in our efforts. The United States Civil Service and many of the larger employers make a definite policy of hiring handicapped employees, and will readily take epileptics providing they can produce a certificate from a qualified medical practitioner stating that the applicant is under medical treatment and that the disease is well controlled. They have a theory that epileptics should work in pairs or groups, so that, in case of necessity, one can help the other. In Canada, we find it quite hard enough to find them employment singly, let alone in pairs.

It is comparatively simple to evaluate the work capacity of a physically disabled person but the process is infinitely more difficult in the type of epileptic that I have been discussing. I recently read an article entitled "The Employment of Epileptics" in a pamphlet issued by the American Epilepsy League. The authors quote the results of a study of 1,105 patients (608 men and 497 women). Of this number, they state that 51% were fully able to work while under treatment and 28% were partially able. Only 18% were unable to work owing to seizures, with a

further 3% for other reasons. To sum it up, out of 1,105 typical epileptics, only 21% are unable to work while undergoing treatment. What we want to know is, of those who come to us for employment, how can we pick out the 79% who can work?

We need to know the type, the frequency, and the duration of the seizures. This is of the utmost importance when considering a suitable job for the individual. We should also know whether there is any aura or warning of the seizures and whether they come at any set time of the day or night. For example, there is an epileptic working steadily as an oiler on one of the coastwise steamers. We found that after treatment he only suffers about one seizure a month and that one invariably during the night. He has been on the job now for nearly a year without encountering any difficulty—on the day shift.

Another important consideration is whether there is any mental deterioration present, as many epileptics give the poorly informed interviewer this impression. We laymen certainly need guidance on such problems as this. We should also know details as to the general physical condition of the applicant, what working conditions will aggravate his disability, and what type of work will alleviate it.

Epilepsy as a School Health Problem

MARY E. HAWKINS, B.A.Sc.

Average reading time — 3 min. 12 sec.

IT MUST BE realized that when speaking of the attitude of the schools toward epilepsy, there are two points of view to be considered—that of the school teachers and principals; that of the school health department. In order to gain the necessary information, numerous members belong-

ing to both groups were interviewed and many interesting facts were brought to light.

In considering the problem from the point of view of the teachers and principals, the first thought was that the epileptic child deserves an education just as much as any other child. The consensus was that if the parents will co-operate with the school, and if the seizures are not so frequent that they cause too great a

Miss Hawkins is a staff nurse with the Metropolitan Health Committee in Vancouver.

disturbance in the classroom, the school is perfectly willing to accept the child. They felt that he should be allowed to lead as normal a life as possible and that only dangerous activities should be restricted. It was strongly felt, by at least one principal, that the parents should take the initiative in restricting a child and instructing him about his condition. Most teachers seemed to have a fairly good understanding of the condition and to be acquainted with the first aid measures but there is room for improvement in some cases. There is very little trouble with the other students, most of them accepting epilepsy as something comparable to a visual defect. The main emotions shown when a child had a seizure were usually interest and sympathy. This, then, briefly presents the attitude of the school personnel.

The Health Service felt, as did the school authorities, that the child should be kept in school if it is at all possible. They wish to help him in every way but do ask for parental co-operation, both in informing them about cases and also in helping to educate the child as to his limitations. It is also urged that the child be kept under constant medical care, both for his own sake and also for the protection of the school.

The public health nurse's role in the care of the epileptic child in school is almost entirely one of

education. She is very rarely present when a seizure occurs in the classroom so it is her responsibility to see that the teachers of every child with this condition are aware of the essential first aid treatment. Not only that, but she must explain the condition to the teachers so that they will have a better understanding of the child and not be nervous about having him in the class. It is the public health nurse's business to visit the parents and discuss the child's condition with them. She should point out that epilepsy is not a matter of shame as so many adults seem to think. She should try to get the child under medical treatment and explain his limitations and also his abilities to the parents. The goal in the care of the epileptic child is to allow him to lead as normal a life as possible without risking serious injury. She should stress that the child is not an invalid and should not be treated as such. It is her role to interpret the school's attitude to the parents so that both can work in harmony. In epilepsy, particularly, the public health nurse can be the link between the school and home, thus helping to make the patient a healthier, happier child and, later, a better-adjusted adult. The attitude of his home and school in these formative years will largely determine whether he will be a social parasite or a productive member of society.

Bile

The quantity of bile secreted within the liver in a 24-hour period varies from 500 to 800 cc. The amount of bile formed is subject to many modifying influences, both normal and pathologic. Pathologic factors known to diminish bile secretion are infectious diseases such as pneumonia, typhoid, pulmonary tuberculosis, and high body temperatures due to any cause. Obviously, specific liver damage in such conditions as carcinoma of the liver, phosphorus, arsenic and similar poisonings, amyloid degeneration and yellow atrophy will result in diminution of bile synthesis. Drugs which diminish the synthesis of bile are

ethyl alcohol, barbiturates, chloroform, and morphine.

Increased flow of bile can be produced by any one of several means. Bile acids themselves provide the liver with suitable starting material for the synthesis of new bile. A high protein diet will also aid materially in providing the liver with building material from which new bile can be formed. Practically all other substances which do result in an increased flow of bile either stimulate the secretion of bile by the liver cells or initiate the emptying from the gallbladder of bile previously stored.

—*Journal of the American Medical Association*

Nurses Can Influence Thinking

MARGERY W. SMITH, M.A.

Average reading time — 8 min. 48 sec.

NURSES little realize the influence they exert upon the thinking of people on every level including the international. Nurses become magicians to folk struggling to get well. These people confide in her, accepting her word as law. During convalescence they assume the constructive attitudes she may inculcate into their minds.

Nurses, through their varied services, have access to every home in the world. In these homes they can plant seeds of understanding of what causes peace, what causes war, and the part each plays in bringing about these states.

For countries to maintain peace and preserve wholesome principles the citizens are expected to understand and practise constructive human relations. These words are often spoken glibly, as though just to say them is for everyone to understand them. Yet even extensive educational systems fail to give a practical appreciation of constructive human relations to the students.

Nursing education has long been devising working plans for teaching nurses how to maintain constructive attitudes in all the units of their work. In spite of the intelligent recognition by administrators of this need, outsiders frequently place an accusing finger on a vulnerable spot in our system. In the Brown report, *Nursing for the Future*, we read:

P. 46—*Hospitals* are predominantly operated on *authoritarian* principle rather than that of a co-operative team relationship . . . The *nursing service* is highly *authoritarian* . . . develops socially undesirable characteristics . . . *subservience* to persons above, *mastery* of those below.

P. 74—The nurse should have a sound understanding of *human behavior* and *human relationships*.

Miss Smith is chief nurse in the Bellevue Psychiatric Hospital, New York.

P. 91—The *authoritarian attitude* is one of the greatest handicaps. There can be nothing short of a revolution in the philosophy and practice . . . to *give the nurse opportunity to grow toward gentleness, kindness, inner quietness, security, sensitivity, essential for performing the healing art*.

Many nurses do not recognize that the authoritarian attitude they assume impedes progress, holding back the development of initiative and the assumption of responsibility by those under their direction.

When nurses understand the basic factors of human relations involved, they can bring about a *quiet, unostentatious revolution*. They can live it, teach it, and breathe it through every move they make. But they must have a complete understanding of the factors involved and a zeal to win. They must recognize that—

Constructive human relations must show in all activities.

The constructive attitude will not stay won but requires constant watching and preserving to keep it evident.

Actually, in nursing institutions three distinct schools of administration function at the same time. Basically, the three schools set the same objectives—namely, to run a hospital smoothly, efficiently, considering the best interests of the patients, the personnel, and those financially responsible for the institution:

THE FIRST SCHOOL: *Militaristic, authoritarian, autocratic*—Modern nursing had its inception in a military setting at the Crimea. It followed the military pattern where the individual obeyed instantly, without question, the commands of the officer. Many nurses still administer arbitrarily, steeped in autocratic methods.

THE THIRD SCHOOL: *Progressive, creative, democratic*—respects the opinions of the individual, gives each member of the organization opportunity for the expres-

sion of her ideas; *encourages*, always, even in the face of difficulties, giving the nurse an opportunity to be proud of herself, not *cutting off her constructive strivings*.

THE SECOND SCHOOL lies between these two. It is most difficult for the staff to understand. Here, administrators give lip service to the democratic school, teach the individual to develop initiative, urge her to express herself creatively. Then, having encouraged her to action, making her more vulnerable for having exposed her deeper thoughts, they strike her, humiliating her to non-action, letting her see her shoots of constructive action wilt and die, requiring her to follow without resistance along the path they lay out. This second school may be called unconscious because those adhering to it are unconscious of how they are blocking progress by the reactions they stir up among the people for whose work they are responsible. They call themselves modern, aiming at fine professional service, excellent personnel relations, but then, when a staff member grows enthusiastic, they grow panicky, fearing the loss of control, and revert to the militaristic school. Here they find solid ground.

An authoritarian does not understand philosophy, does not believe that there can be different viewpoints on issues. He feels that workers must think as he does or get out. He can not understand the democratic principle that people with notions that are divergently different from his can help him build a better institution. Many authoritarians are reciting to their subservient staffs, "Now we are running a co-operative team relationship!" Mechanically, they are manipulating the field in true authoritarian style, pushing the pawns around to accomplish their ends.

Democracy grows from within. There are fundamentally basic factors in human relations which every individual must understand and use even in the minutest issue if he is to gain insight. First he should ask himself *to what philosophy of life he holds*. The following primary concepts will serve as a guide until he conceives a better one:

A tiny germ of life is born in the individual. With each response to a stimulus the seed sends out vital shoots. At the same time power is absorbed in the seed itself from the source of all life and added power comes into the core of the seed. Each new response makes the shoots stronger and ever more power comes into the life of the individual as the living substance grows, leading to undreamed heights.

Constructive forces: Love, thoughtfulness, and kindness nurture the plant to these undreamed heights, drawing ever from the source of life.

Destructive forces: Fear, hatred, worry, envy, jealousy, and unkindness nurture unhappiness, stunting the growth of the plant, developing a warped individual who is incapable of carrying the potentialities to full fruition. Something hurts the individual when these forces are given play.

The authoritarian cuts off these shoots when he feels they may interfere with his plans, not realizing how they could be developed into a constructive power for the good of the institution.

Fichte, in his *Vocation of Man*, 1890, stated:

If each individual could develop his potentialities to the extent of his power it would change the world for the good of all mankind.

Milton Wright, in *Getting Along with People*, claims that human reactions are predictable. We get back what we give. He outlines the basic factors in human relations as:

Every individual exerts an influence upon every other individual with whom he comes in contact, whether he talks to him or passes him. He rouses that person to feel *elation*, to react buoyantly, happily, with a feeling of goodwill, with *self-assertion*, or he rouses him to feel *dejection*, to react unhappily, with fear, with anger, with hatred, with a feeling of resentment, with *self-debasement*.

The stimuli that start reactions put drive behind boomerangs. These come back to strike the originator with greater force than they had at starting.

If he rouses the individual to self-assertion, the individual, in turn, radiates joy, happiness, constructive creative

activity. He influences his contacts. A power of goodwill emanates from all in the entire course of the boomerang, welding them together in unified force, to return to the sender a constructive integrated service well done.

If he rouses the individual to self-debasement, the individual in fear, or anger, or dejection, belches forth hatred, jealousy, envy, revenge, striking everyone he meets, to react with the same unholy drive, disintegrating, destructive forces, to return with greater power to the sender than that which he originally sent forth.

Are nurses willing to give everyone, at all times, the chance to be proud of himself? Are they willing to trust him, regardless of his offence, not sitting as a judge over him and "putting him in his place," but rather as a counsellor, a therapist, helping him to gain insight into his problem? Are they getting a broader outlook themselves as they learn what caused the particular offensive reaction?

A good course in counselling and therapy would bring to every nurse a greater understanding of her power. The National Council on Family Relations begs that each nurse be a counsellor, a teacher, at all times. Maturity of judgment brings an understanding of the deep-seated factors involved. A nurse cannot acquire it overnight. Along with the course, practical experience is essential. It takes insight and patience to acquire mature reactions.

The battle for democracy will never stay won without continued intelligent effort, since people are

naturally authoritarian. Authoritarianism is the immature method of ruling. It takes much more patience, insight, vital interest in people, and judgment to be a democratic nurse. Furthermore, for a nurse to gain the insight and judgment needed to be a teacher steeped in democratic principles, she will have to intelligently watch and interpret the reactions of people as she works with them.

No one in a few pages can interpret the psychology, the educational principles, and the values, incorporated in this philosophy of education, so important for the professional nurse of the future to understand. These few factors are basic in an ideal philosophy of life, in creative education, and in constructive human relations. They underlie the structure for wholesome married life and comprehend a basis for a universal religion.

If the nurse can learn to make them work in every phase of her hospital work, she has the key to constructive thinking that can preserve peace among all nations. If she can instil the ideas in the homes of the world, giving every individual the notion of how they work and setting him to the business of using them, she is making practical use of her master key. No nurse is too young to work the magical charm of progress in her own sphere of influence. This movement can gradually be felt by those who sit in the seats of the mighty. Those in authority can be forced to react to the will of an intelligent people.

Congress on Obstetrics

The International and Fourth American Congress on Obstetrics and Gynecology is meeting at the Hotel Statler in New York, May 14 to 19. A complete program for nurses is being developed by Miss M. A. Losty, consultant, Maternity and Newborn Division, New York City Department of Health. Here, the various problems of obstetric and gynecologic care will be considered from the nurse's standpoint.

Registration fee for the Congress is \$10.

For advance registration blanks, travel, or hotel information write to: **Dr. Fred L. Adair, General Chairman of Congress, The American Committee on Maternal Welfare, Inc., 161 East Erie St., Chicago 11, Illinois.**

A new chemical—dihydroxy-dichloro-diphenyl methane—has been found to be a highly active fungicide. It is indicated for therapy of athlete's foot.

Accreditation of Educational Programs in Nursing

MARGARET M. STREET

Average reading time — 7 min. 12 sec.

NEW AND EXCITING developments are taking place in the United States in the accreditation of educational programs in nursing. These developments cannot fail to stir the imagination and open alluring vistas with their deep and broad implications for the advancement of nursing education and nursing service.

Through happy chance, it was my privilege, in August, 1949, to attend a three-day work conference on accreditation held in New York City under the auspices of the National Nursing Accrediting Service. Similar conferences had been held during the same month in New Orleans, Chicago, and Denver. All conferences had the same stated purposes:

1. To acquaint the participants with the significance of accreditation.
2. To prepare effective forms of enquiry to be used in securing the necessary information on which evaluations may be based in the accrediting process.
3. To gain some knowledge of survey techniques.
4. To consider how accreditation may be used to improve nursing education and nursing service in the individual community.

More than 700 nurses, representing all fields of nursing and all states, attended one or other of the work conferences. The New York conference was attended by more than 200 nurses from 20 states. One other Canadian nurse was also present—Sister Denise Lefebvre, who is to conduct the work conference on Evaluation and Accreditation of Schools of Nursing at the forthcoming biennial meeting of the Canadian Nurses' Association in Vancouver.

Miss Street is secretary-registrar of the Association of Nurses of the Province of Quebec.

Both Sister Lefebvre and I were deeply appreciative of the courteous welcome extended to us, and of the opportunity to share in the discussions of this absorbing topic. We also enjoyed the experience of participating in a particularly stimulating form of group dynamics.

As all fields of nursing are closely interrelated and have one common denominator, it seems natural and fitting that six major nursing organizations in the United States should have come together to establish, on April 6, 1949, a Committee on Unification of Accrediting Activities. The sponsoring organizations were as follows: American Nurses' Association; National League of Nursing Education; National Organization for Public Health Nursing; Association of Collegiate Schools of Nursing; National Association of Colored Graduate Nurses; and the American Association of Industrial Nurses, Inc. The personnel of the committee included all presidents and executive secretaries of the participating associations, with consultants from the fields of general education, medicine, and hospital administration.

As a result of the intensive work of this committee, the National Nursing Accrediting Service was established early in 1949. All accrediting activities were brought under this one agency, including those related to: basic nursing programs (non-collegiate and collegiate); public health nursing education; post-graduate nursing education; and non-professional programs for the preparation of practical nurses or nurse technicians. This amalgamation of accreditation procedures in nursing under one banner was a signal achievement which does honor to the courage, initiative, sincerity of purpose, and

broad vision of the nursing profession in the United States. It is clearly recognized, of course, that the establishment of the National Nursing Accrediting Service marks only the beginning of the tremendous task which lies ahead. Careful and detailed plans have been drawn for translating this splendid dream into practical reality. Administrative machinery has been erected with scientific skill and precision. Most important of all, an excellent tool has been devised in the form of the "Manual of Accrediting Educational Programs in Nursing," which was published by the National Nursing Accrediting Service in the latter part of July, 1949. The Manual, as stated in its preface—

Provides a common core of accepted policies, principles, and descriptive criteria which may be applied to any category of nursing education by the responsible board of review and the appropriate accrediting representatives in evaluating a specific educational program in nursing.

It is hoped and expected that the contents of the Manual will also be studied by the faculties of institutions and agencies desirous of seeking accreditation; and that their consequent familiarity with the general criteria, used in the evaluation of nursing programs, will be of great assistance to the institution or agency in preparing for and achieving accreditation. The compilation of this excellent handbook was the work of the Committee on Unification of Accrediting Activities, with the assistance of many nurses throughout the United States. Democratically evolved, it is also to be used democratically. It has been prepared in loose-leaf form, in order that revisions may be made as criteria change or new ones develop.

The purposes of accreditation, as set forth in the Manual, are as follows:

1. To stimulate progressive changes in nursing education that will improve nursing service and provide better health care.
2. To indicate, through published lists,

institutions offering programs of nursing education worthy of public recognition.

3. To describe the characteristics of educational units offering programs in nursing education that are of superior quality.

4. To guide the prospective student in the selection of an educational unit offering programs in nursing.

5. To assist those responsible for schools and programs of nursing and state boards of nurse examiners in providing for the better preparation of nurses.

6. To encourage, within each educational unit, self-evaluation and study of its own problems in nursing.

7. To encourage appropriate groups to engage in suitable experimentation and research in nursing education and nursing service.

The *focal* purpose of accreditation is "to improve nurse education in order that more nurses may be prepared to furnish better nursing service to the public."

The first list of accredited programs of nursing education to be issued by the National Nursing Accrediting Service appeared in the October, 1949, number of *The American Journal of Nursing*. This list was stated to include programs formerly recognized by the Association of Collegiate Schools of Nursing, the Conference of Catholic Schools of Nursing, the National League of Nursing Education, and the National Organization for Public Health Nursing, and recommended by these organizations to the National Nursing Accrediting Service. It is proposed that subsequent lists will be published annually.

To a Canadian observer, the outstanding emphases in the new national accreditation program in the United States are as follows:

1. Accreditation of educational programs in nursing is a responsibility of the nursing profession.

2. The fundamental purpose is one which the nursing profession has recognized in all of its endeavors: "Better education for better nursing service."

3. Accreditation is voluntary. It is freely sought by institutions or agencies, not imposed upon them.

4. National accreditation is not intended to supplant school visiting programs as carried on by state boards of nurse examiners. The National Nursing Accrediting Service will not evaluate the program of any school which has not previously been approved by the state board.

5. Accreditation procedures are to be flexible. Each program will be evaluated in terms of its own stated objectives.

6. The importance of acquainting the nursing profession with the aims, philosophy, and methods of the new national program of accreditation has been recognized, and numerous institutes and work conferences have been held to this end. The steps in the accrediting process have been explained to and studied by groups of nurses attending these meetings. At the work conference in New York, these steps were presented by means of an impromptu dramatization, which was extremely effective and no doubt served to reassure

many who may have been apprehensive about the accreditation process in relation to their own institutions or agencies.

Canadian nurses will watch with keen interest the progress of the National Nursing Accrediting Service in carrying out the challenging task which has been assigned to it.

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Nursing Sisters' Association

Last year the *Edmonton Unit*, now 31 members, decided to revert to a social club, as in the pre-war days, since all members are very active in other organizations. The executive for 1950 is as follows: President, Mrs. D. W. Rosser; vice-president, Margaret Thompson; recording and corresponding secretaries, Betty Farquharson and Mrs. C. B. Kidd; treasurer, B. Cole; representatives to: United Nations Association, E. Robinson, A. Dickson, B. Farquharson; Canadian Corps, Mrs. C. E. Anderson. The past president is Mrs. B. Morrison.

The unit was sorry to lose as members: Miss Baldwin, from Government House Convalescent Home, to go to Deer Lodge, Winnipeg; Irene (Beckler) Scott who is residing in Montreal; Shirley (Lane) Murray.

Margaret Thompson is with the city health department. She is president of the Quota Club and divisional officer with the reserve army of nurses. Ann Dickson is public school nurse with the city schools. B. Farquharson is doing private duty in the city. Beatrice Cole is taking the course in teaching and ward supervision at the University of Alberta. Frances Payne, former

corresponding secretary, is secretary to Dr. John Scott, dean of medicine, University of Alberta. Helen (Bradley) Laycraft is instructor in public health at the university. C. Brown is nursing arts instructor at the University of Alberta Hospital while Helen Hamilton is science instructor there.

St. Regis Hotel was the scene of the annual dinner of the *Winnipeg Unit* when Dr. Athol Gordon gave an interesting and informative talk on "The Coroner and His Place in the Community." A general meeting and installation of officers followed the dinner when the following members were elected to serve during 1950: President, E. Watts; vice-president, F. McLeod; recording and corresponding secretaries, J. Lylyk, O. Stuart; treasurer, E. Haines; committee conveners: social, F. Spencer; visiting, M. Muir; Memorial Day, Miss Hudson; Poppy Day, Mrs. W. J. McCord; publicity, A. Maloney; advisory board, H. E. Wilson, Mmes N. Smith, L. Rabson, J. D. Moulden.

During the past year, a bridge party, Spring Tea, and Armistice Day Tea were held, the proceeds going to the Building Fund of the Children's Hospital.

Nursing Profiles

Kathleen Grace DeMarsh is the director of Outpost Hospitals with the Saskatchewan Division of the Canadian Red Cross Society. Born in Saskatchewan, Miss DeMarsh graduated from the Saskatoon City Hospital in 1941 and received her certificate in teaching and supervision in schools of nursing from the University of Toronto School of Nursing. After three years as director of nurse education at the Brantford General Hospital, she launched the first Red Cross nursing station in New Brunswick. She engaged in pioneer visiting nurse service for two years at the Miscou-Shippegan Nursing Station on Miscou Island. In 1948, Miss DeMarsh was given a special assignment by the Canadian Red Cross Society. For ten months she devoted her time to the task of re-writing their Home Nursing Manual.

Like most of us, Miss DeMarsh feels she would be happy to have two extra hours in every day, two extra days in every week in order to do all the things she wants to do. Her hobbies are badminton, African violets, and people—especially people!



KATHLEEN DEMARSH

M. Vicki LaRose has taken up her duties with the New Brunswick Division of the Canadian Red Cross Society in the capacity of provincial director of Red Cross nursing services and nursing stations. Born at Grenville, Que., Miss LaRose graduated from the Homoeopathic Hospital, Montreal, in 1923. She took a post-graduate course in tuberculosis work and was on the staff of

the Western Maine Sanatorium. In 1930 she became public health nurse with the Argenteuil County Health Unit in Lachute, Que., resigning in 1942 to enlist as a nursing sister with the R.C.A.F. When she was discharged in 1946 she became supervisor of social services with the Venereal Diseases Division of the Quebec Ministry of Health. Completely bilingual, Miss LaRose speaks French and English with equal fluency. This will be a great asset to her in the expanding program in New Brunswick.



VICKI LAROSE

Margaret Godfrey has been named executive director of the Children's Aid Society of Cumberland County, N.S. Born at Wolfville, Miss Godfrey is a graduate of the Saint John General Hospital, N.B., and of the Maritime School of Social Work. During World War II she served as a nursing sister with the R.C.A.M.C.

Kay Feisel, a graduate of the Regina Grey Nuns' Hospital, has assumed her new duties as director of nursing at the McKellar Hospital, Fort William, Ont. Miss Feisel went overseas in World War II with the R.C.A.M.C. and was in charge of hospital units in Italy and Northwestern Europe. She was assistant matron of a 300-bed occupational force unit in Germany. Prior to the war, Miss Feisel was science instructor at Holy Cross Hospital, Calgary. She ob-

tained her certificate in administration in hospitals and schools of nursing from the McGill School for Graduate Nurses in 1948.

Mabel M. Stewart, a graduate of the former Lady Stanley Institute in Ottawa, was honored on the occasion of her 25th anniversary as lady superintendent of the Royal Ottawa Sanatorium by the medical, nursing, office, and dietary staff at a luncheon on December 21, 1949. She was presented with a gold wristwatch by Dr. D. A. Carmichael on behalf of the doctors and a corsage bouquet by Miss P. A. Walker. Dr. Carmichael expressed the staff's appreciation of Miss Stewart's able administration during the long years since she assumed her position. Miss Stewart was given a silver tray and a bouquet of roses, which were presented by Miss M. Thompson on behalf of all the staff.



Ashley & Crippen

JEAN E. BROWNE

Jean Elizabeth Browne, who has been national director of the Canadian Junior Red Cross for the past 28 years, retired at the beginning of this year. Born in Park Hill, Ont., of English and Highland Scottish parents, Miss Browne's career of teaching and organizing began when she graduated from the Toronto Normal School. After teaching for three years she entered upon her nursing training at the Toronto General Hospital where she graduated in 1910. The following year she went to Regina to organize a school nursing program. Six years later she was invited to extend her activities in public health by organizing a School Hygiene Branch in the Saskatchewan Department of Education. She remained as director of this service until 1922 when she moved into the national field with the Canadian Red Cross Society. Under her direction and stimulation the Junior Red Cross movement has flourished until today there are nearly 900,000 members in schools across Canada. Miss Browne feels there is "reason for great optimism" where our young people are concerned.

"They are interested and eager to accept responsibility, help others, and are doing much to promote international friendship."

Miss Browne has always taken an active interest in the activities of the nursing profession. She was the first president of the Saskatchewan Registered Nurses' Association and in 1917 assisted in securing their Registration Act. From 1922 to 1926 she was president of the Canadian Nurses' Associa-

tion. It was during her term of office that the Nurses National Memorial in the Peace Tower in Ottawa was erected and dedicated. She was secretary of the Joint Study Committee for seven years; from 1934 to 1938 she was chairman of the C.N.A. Legislation Committee and for eight years was convener of the Exchange of Nurses Committee. Internationally, Miss Browne has been almost as well known as at home. In 1920 she took post-graduate work at Bedford College, London, and nine years later she gave a course of lectures there on methods in health education.

In acknowledgement of her services, Miss Browne has received many awards. She holds both the George V Jubilee Medal and the George VI Coronation Medal. She was awarded the Mary Agnes Snively Medal by the nurses of Canada in 1938. She has received the medal of the Danish Red Cross and is one of the handful of Canadian women who holds the Florence Nightingale Medal, the highest nursing award in the world. In her well-earned rest, her thousands of friends will wish her abundant health and happiness.

Catherine L. (Anderson) Townsend has relinquished the responsibilities she has carried faithfully for many years as instructor at the Montreal General Hospital and as chairman of the Board of Examiners of the Association of Nurses of the Province of Quebec. Born in Scotland, Mrs. Townsend



Notman, Montreal

CATHERINE TOWNSEND

received her education in Westmount, Que. When she graduated from the Montreal

General Hospital in 1932, she was awarded the Mildred Hope Forbes Scholarship for highest aggregate standing during her three years. She enrolled in the McGill School for Graduate Nurses the following year and completed the work for her certificate in teaching and supervision. Returning to M.G.H., Mrs. Townsend became a head nurse and instructor in surgical nursing. After 1938 her time was all spent in the classroom. Despite her marriage to Dr. Stuart R. Townsend, medical consultant with the R.C.A.F., in 1943, she continued as an instructor as a wartime duty. Now, four years after the close of the war, Mrs. Townsend is going to devote her time to her home and husband. With gardening as her favorite hobby, she will have a busy time. Mrs. Townsend is continuing to act as chairman of the Scholarship, Loan and Bursary Committee of the C.N.A.

In Memoriam

Mary A. (Holt) Armstrong, who graduated from Saint John General Hospital, N.B., in 1895, died on December 17, 1949, following a serious illness of four months. For a number of years following graduation Mrs. Armstrong engaged in private nursing until her appointment as school nurse for Saint John in 1915. She retired in 1941.

* * *

Florence Embury died on January 2, 1950, at the age of 84, after a long illness. Miss Embury had retired from nursing many years ago.

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Mary Elizabeth Fisher died on November 28, 1949, following a brief illness. Born in Ontario, Miss Fisher had trained and spent the great part of her professional life in New York City. When she retired some ten years ago she returned to Canada to live.

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Birdle (Campbell) Gowans, a graduate of St. Luke's General Hospital, Ottawa, died in Montreal on December 22, 1949.

* * *

Eleanor (O'Brien) Hishon, who graduated from the Royal Victoria Hospital, Montreal, in 1918, died on January 9, 1950. Mrs. Hishon took a course in x-ray work soon

after she graduated. She engaged in private duty for a short time prior to her marriage.

* * *

Mary C. MacQueen died on November 30, 1949, following a year's illness. Graduating from a New York hospital, Miss MacQueen was assistant superintendent of nurses for a time at the Toronto General Hospital and also at the Toronto Western. Forced to leave her professional life by impairment of her hearing, Miss MacQueen had resided in Manilla, Ont.

* * *

Violet (Davies) Meekins, a graduate of St. Luke's General Hospital, Ottawa, died recently at Long Beach, Calif. Mrs. Meekins served overseas during World War I.

* * *

Katherine Theresa O'Connor, who graduated from the Ottawa General Hospital, died on December 25, 1949, following a lengthy illness. Miss O'Connor engaged in private nursing for a number of years before being appointed to the staff of the Ottawa Department of Health where she later became supervisor. She retired from active work in 1937.

* * *

Maude E. Retallick died in Saint John,

N.B., on December 29, 1949. A graduate of the Massachusetts General Hospital, Boston, Miss Retallick held several responsible supervisory positions there before assuming the post of superintendent of nurses at the Saint John General Hospital in 1913. For the next seven years she filled this position most capably.

Miss Retallick was a pioneer in the endeavor to elevate and maintain the standards of her chosen profession on a high plane. It was largely due to her untiring efforts that the Act of Incorporation of the New Brunswick Association of Registered Nurses was passed in 1916. She volunteered to act as secretary in addition to her full-time duties. By 1923, the association work had grown to such an extent it was necessary to employ an executive secretary. Miss Retallick was chosen for the position. Until her retirement in 1941, her leadership, interest, and wide knowledge of nursing affairs were given wherever the need arose. She was also the first school of nursing visitor for New Brunswick. Miss Retallick will long be remembered for her wit and clear thinking in association affairs.

* * *

Donaida Robertson, a graduate of the Royal Alexandra Hospital, Edmonton, died in Toronto on December 2, 1949. Miss Robertson served overseas during World War II with the R.C.A.M.C. She was appointed matron of Dundurn Hospital in Saskatchewan upon her return. For the past year she was on the admitting office staff of Toronto Western Hospital.



FLORENCE WALL

Florence (Newell) Wall, who graduated from Sydney City Hospital, N.S., in 1931, died suddenly on November 13, 1949, at the age of 45. Mrs. Wall was night supervisor at the Sydney hospital for a number of years.

* * *

Margaret Morris Watson, who graduated from the Children's Memorial Hospital, Montreal, in 1923, died the end of December, 1949, in Stafford Springs, Conn., where she was nursing superintendent of the Johnson Memorial Hospital. Miss Watson returned to the staff of C.M.H. as a supervisor two years after graduation. In 1927, she completed the public health nursing course at the McGill School for Graduate Nurses. She joined the staff of the Victorian Order of Nurses for a short period, going to the Shriners' Hospital in Springfield, Mass., in 1928.

Quebec Industrial Nurses

A three-day conference on *Industrial Nursing* is planned for *May 15, 16 and 17, 1950*. It is to be held at the McGill School for Graduate Nurses and is sponsored by McGill University and the Association of Nurses of the Province of Quebec. This is advance information so that management and personnel of the health centre of each industry may formulate plans for as many of their nurses to attend as possible. Letters will be sent to management and the nurses in industry with more complete information. For further details write to: **The Secretary, McGill School for Graduate Nurses, 1266 Pine Ave. West, Montreal 25, Que.**

Weather Man—Please Note!

Will spring come early to B.C. this year? Why are we interested?

Because Kelowna—situated on Lake Okanagan in "The Valley of the Blossoms"—has been selected as the scene of this year's annual meeting of the R.N.A.B.C.

Kelowna, a city noted for its beauty and hospitality, has been the venue of many conventions and is now waiting to welcome us. It is easily accessible by rail, air, or road—only 300 miles by car from Vancouver.

Excellent hotel accommodation.

The dates—The week-end after Easter—*Thursday, April 13*: Educational program; *April 14-15*: Business meetings.

Private Duty Nursing

Aniline Dye Poisoning of Babies

HELEN CLAIRE HOWES

Average reading time — 7 min. 48 sec.

NOT LONG AGO in Florida, three newborn babies died and two others were made seriously ill from what was reported in the press as "a strange ailment that turned them a mysterious blue color." One would think there had been enough case reports in the medical journals and news items in the daily press for hospital authorities to recognize the signs of poisoning from aniline dye. As a matter of fact, eight reports have appeared in medical journals, involving some 72 cases, with 5 deaths. The 3 deaths noted above bring the total to 8 babies, all dead from the same cause—aniline dye intoxication. This dye is commonly used to mark hospital linen, wash cloths, diapers, etc. It takes very little aniline, indeed, to cause intoxication, even in an adult.

The signs of aniline dye intoxication are distinctive so that the condition is not difficult to diagnose. The skin shows a grayish-blue cyanosis. There is marked apathy and there may be vomiting and anorexia. In very severe cases there may be convulsions and other nervous symptoms, and cardiac disorders. Bronchopneumonia frequently develops and, when death occurs before pneumonia develops, some maintain death is caused by the toxic effect of aniline on the heart.

Aniline is a colorless, oily liquid, derived from the reduction of nitrobenzene. (One report stated that there had been an odor of shoe polish around the nursery for several days prior to finding the infants cyanosed.) When exposed to air, aniline turns from yellow to brown. It mixes readily with alcohol, ether, benzene, or chloro-

form, but not readily with water. Aniline is used in the manufacture of dyes and rubber. The dye used for stamping usually contains nigrosin for color, aniline oil to fix it, and oil of nitrobenzene to dissolve the mixture.

Aniline dye is used to mark linen because the mark does not wash out, whereas other types of ink are not permanent. Bottles of stamping ink are usually labelled thus: "This ink contains Aniline Oil which must be removed by laundering before the marked article is stocked or worn." Even if the bottle is not marked, it should be (and probably is) the rule in every hospital that all newly-marked linen should be boiled immediately and thoroughly dried before use. If this precaution is taken, aniline oil dye is absolutely harmless; if this precaution is not taken, it is deadly, particularly to babies.

Human beings may be poisoned by linen, freshly stamped with aniline dye, in three ways: (a) inhalation of the aniline or nitrobenzene fumes, (b) absorption through the skin, and (c) by ingestion. As would be expected premature infants are more easily affected than full-term babies, doubtless because their skin—indeed the whole mechanism of the body—is more delicate. If prematures, who are living in the close confinement of the incubator, are diapered with unboiled, aniline-dye stamped linen, they are exposed to the dye through two channels: (a) the lungs, from inhaling the vapor, and (b) the skin of the buttocks, from absorption, particularly if diarrhea has caused excoriation.

In one report, diapers were tied

around the babies' necks as bibs. A baby in the sucking stage can very easily tuck a stamped corner into its mouth. In another report, the wash cloths that had been used on the babies turned the water black when wrung out.

In the body, aniline causes the ferrous iron in the hemoglobin to be turned back to ferric iron and acts on the hemoglobin to form methemoglobin. Since methemoglobin is not able to give up its oxygen, it cannot act as an oxygen-carrying pigment. There is not enough hemoglobin available to transport oxygen from the lungs to the tissues. (Prematures are especially susceptible to a diminished supply of oxygen.) The blue-grey color of the cyanosed baby may develop because of the dark color of the blood or because of the lack of oxygen in the tissues. Some clinicians believe the cyanosis to be due to a pigment formed in the subcutaneous tissues by the aniline itself.

Treatment in the past has consisted of, first and foremost, removal of the offending linen from the baby and the room, and the fumes from the atmosphere. Oxygen inhalation and blood transfusions have been given and injections of methylene blue. Workers at the Touro Infirmary in New Orleans (*J.A.M.A.*, Aug. 18, 1945) believe oxygen and methylene blue to be unnecessary and transfusion required only where the condition is acute. On the other hand, Scott *et al* (reporting 32 cyanosed babies in *J. Pediatrics*, 1946) stated that the injection of methylene blue intravenously brought a dramatic recovery in one infant, cyanosis disappearing in an hour. There were 3 deaths in this series.

In the latest report, covering aniline intoxication in 9 prematures in Chicago (*J. Pediatrics*, May, 1949), Kagan and his associates state that there is considerable disagreement regarding the value of methylene blue in treating these cases. It is believed that in high concentration methylene blue converts the ferrous iron to the ferric form and methemoglobin, whereas in low concentra-

tion it apparently reverses this process so that, following the intravenous injection of small amounts of methylene blue, methemoglobin rapidly disappears from the blood and is replaced by an equivalent amount of hemoglobin.

In this last series of cases, something new was added to the treatment of aniline dye intoxication—i.e., ascorbic acid in doses of 100 milligrams orally once or twice. Vitamin C has marked reducing properties, which provides the rationale for its use. Kagan *et al* state, however, that its therapeutic effect is difficult to assess since improvement was immediate in all cases as soon as the offending dye was removed from the environs of the baby. Nevertheless, there is evidence that the use of ascorbic acid in the diet of some of the babies may have prevented cyanosis from developing in the first place. Of the 9 who became intoxicated, 8 had never had ascorbic acid in the diet. The other one, whose symptoms were very mild, had received 25 milligrams of ascorbic acid daily for two months. On the other hand, of the 20 in the nursery who did *not* develop intoxication at all, 10 had received 25 mg. ascorbic acid daily for one to 8 weeks; one had received 100 mg. of ascorbic acid daily for a week, and 5 had received 30 to 90 cc. of fresh orange juice daily for 7 to 10 days. Kagan's work suggests that vitamin C-deficient babies are more susceptible to aniline dye intoxication than babies with a high ascorbic acid blood level.

These workers stress two points: (a) that such tragedies can be prevented by simple measures, and (b) that aniline intoxication can be treated satisfactorily, even in premature infants, if recognized early enough.

Hospital authorities will say that the first point is not so simple when hospitals are short-staffed, with rapid turnover. The fact remains, however, that adherence to a strict aseptic technique in handling all linens entering the nursery would prevent tragedies of this nature. Surely all new personnel could be made acquainted with the "shoe polish"

odor of aniline dye, the signs of cyanosis, and the terrible possibilities in delayed treatment.

And to the usual methods of treatment might be added the administration of vitamin C, not only to cyanosed babies, but on a prophylactic basis to all babies as early

as possible after birth. (There are, of course, other important reasons why all children should have vitamin C regularly.) This procedure may prove to be a significant measure in preventing possible aniline intoxication in babies, regardless of where they are exposed to the poison.

In the Good Old Days

(*The Canadian Nurse*, March 1910)

"Housekeeping in a hospital 140 miles from a townsite had some interesting features. Our laundry, for instance, had all the advantages of travel—going down to Vancouver one week and returning the next—except on one memorable occasion when the bundles got unaccountably mixed, and the clean wash took the round trip while Miss F. and I faced an awful dearth of linen with what philosophy we could."

* * *

"Since 1903, the Women's Hospital Aid Society of Brantford, by their exertions, have bought and handed over an ambulance for contagious diseases, costing \$410. A new laundry has been built and equipped with the best steam laundry plant, at a cost of \$2,548; \$139 was spend in furnishing a sitting-room for the nurses. An elevator for the use of patients, costing \$1,000, was partially paid for by the W.H.A."

* * *

"We take great pleasure in announcing that the new hospital at Oshawa, which is now being erected at a cost of \$10,000 and will have 14 beds, is to be opened on or about June 1, 1910."

* * *

"Toronto General Hospital has just received a donation of \$250,000 from one of Toronto's favorite sons, Mr. J. C. Eaton, who presents this large gift in memory of his father, Mr. T. Eaton. The gift will build the surgical wing. The outdoor department will be proceeded with this spring."

* * *

"Are all our readers careful to take care of their own health? Do you ever go without your dinner, or your breakfast, or your lunch, or your hours of sleep? Don't begin bad habits. It is so easy to begin being careless about your health.

"Take care of your health. There have been men who, by wise attention to this point, might have made great discoveries, written great poems, commanded armies or ruled states but who, by unwise neglect, have come to nothing. Imagine an oarsman in a rotten boat: what can he do there but by the very force of his stroke expedite the ruin of his craft? Take care then of the timbers of your boat. And this is not to be accomplished by desultory or intermittent efforts of the will but by the formation of habits."

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Cornwall: *Edna C. Lawson* (Hudson City Hosp., N.Y.). Galt: *Donna Thompson* (Kitchener-Waterloo Hosp.). Hamilton: *Dorothea Lea* and *Roberta Mathie* (St. Joseph's Hosp., Hamilton). Vancouver: *Sylvia Junek* (Winnipeg Gen. Hosp.).

Transfers—*Joyce Curran* from Galt to Waterloo, Ont., as nurse-in-charge; *Helen Keith* from Yarmouth, N.S., as nurse-in-charge to Port Arthur, Ont., as nurse-in-charge; *Helen Seibert* from Waterloo as nurse-in-charge to Toronto.

Resignations—*Jean Conlogue* from Saint John, N.B., *Isabel Kemp* and *Anna Knecht* from Montreal, *Marjorie McIntosh* from Port Arthur as nurse-in-charge, and *Elizabeth Morrison* from Vancouver.

Blood typing has already resulted in a marked decrease in infant deaths due to the Rh factor. Such deaths will be further reduced when routine typing is done on all pregnant women.

Institutional Nursing

Esophagectomy and Gastro-esophagostomy

NORA COSH

Average reading time — 13 min. 36 sec.

CARCINOMA of the esophagus is one of the most distressing forms of malignant disease pursuing a relentless course until the patient succumbs as a result of starvation or some complication, unless relief is brought. It is a disease largely of elderly men but often occurs in women between the ages of 50 and 70 years. So many of these patients present themselves for treatment when the disease is beyond the bounds of surgical extirpation and only some form of palliative treatment can be given them. Early recognition of the symptoms is, therefore, necessary in order to reach the diagnosis while the disease is still operable. Palliative operations such as intubation or gastrostomy extend the patient's life for only a very short time.

The most favorable site of carcinoma in the esophagus is the lower third and the esophagus-gastric junction. This carcinoma can be eradicated by transthoracic partial esophago-gastrectomy. By this technique a radical resection of the area affected can be achieved and in addition restoration of the alimentary tract is established by means of an esophago-gastric or esophago-jejunal anastomosis.

HISTORY

Mrs. Mann, age 51, is a charming, intelligent woman. In March, she experienced vague pains about the lower chest. In April, she began to have pain

behind the lower sternum when she swallowed saliva. This would be relieved by belching. Two months later she first noticed difficulty in swallowing solids. Food seemed to stick behind the lower sternum and at the end of the meal she would frequently regurgitate a few mouthfuls. Shortly after this she began to have a continuous dull aching pain through the chest from the lower sternum to the back.

On August 31, barium swallow revealed narrowing of the esophagus at the junction of the lower and middle third, apparently from pressure from without. Deep x-ray was given at this time.

On November 26, an esophagoscopy showed a fungating tumor extending from the level of the aortic arch downwards for a distance of three inches. The biopsy report showed squamous cell carcinoma, grade one.

Mrs. Mann had been on liquids only for two weeks prior to admission to hospital. She had lost 20 pounds in a few months. Upon examination it was noted that she was slightly pale but was still well nourished. Lymph nodes in the neck and axilla were not palpable. The spleen and liver were not enlarged. Chest was clear, heart sounds were normal. Blood pressure was 140/100. There was no tenderness on pressure over the spinous processes of the thoracic vertebrae.

X-rays showed an irregular filling defect in the esophagus extending downwards from the level of the aortic arch for a distance of four inches.

OPINION OF ATTENDING PHYSICIAN

This was a very extensive carcinoma of the esophagus. No evidence of secondaries could be found and there was no indication that it had involved either the bronchi or recurrent

Miss Cosh, a 1948 graduate of the school of nursing of the Vancouver General Hospital, was engaged in general staff nursing on a women's surgical ward there when this patient's case was studied.

laryngeal nerves. However, it seemed to be adherent to the surrounding structures and might be inoperable for this reason. The fact that it was a squamous cell carcinoma, grade one, was in her favor. A left thoracotomy was indicated. If the tumor was not too adherent, it should be recessed and a gastro-esophagostomy performed.

PRE-OPERATIVE TREATMENT

Mrs. Mann was admitted to hospital December 17, only three days before the date scheduled for the operation. Many of these patients are in poor health with a markedly subnormal degree of nutrition due to dysphagia extending over a variable period of time. The diet should, therefore, be nutritious and of high caloric value. Food with a caloric value of 3,000 should be taken in each 24 hours. The diet is adjusted to the dysphagia present and semi-solids and fluids are given. The diet is high in protein and carbohydrate. Dehydration is dealt with so that the water balance of the body is restored. The plasma proteins in the blood are estimated and if subnormal in amount the deficiency is corrected by dietary measures supplemented, if necessary, by protein hydrolysates or a plasma transfusion given intravenously. The blood chloride level is determined and any deficiency is corrected giving increased amounts of sodium chloride. An adequate amount of vitamins should be given, specially riboflavin, thiamine, and ascorbic acid.

When dysphagia prevents the patient from taking an adequate amount of nourishment it may be necessary to perform a jejunostomy and give feedings for a period of three weeks before a partial esophago-gastrectomy is performed.

Any secondary anemia present is corrected. If the hemoglobin is below 70 per cent, one or more transfusions of whole blood are required to correct the deficiency. Mrs. Mann's hemoglobin was 85 per cent.

Chemotherapy of procaine penicillin, 300,000 units, a.m. and h.s.,

is given routinely, pre-operatively and post-operatively.

PREPARATION FOR OPERATION

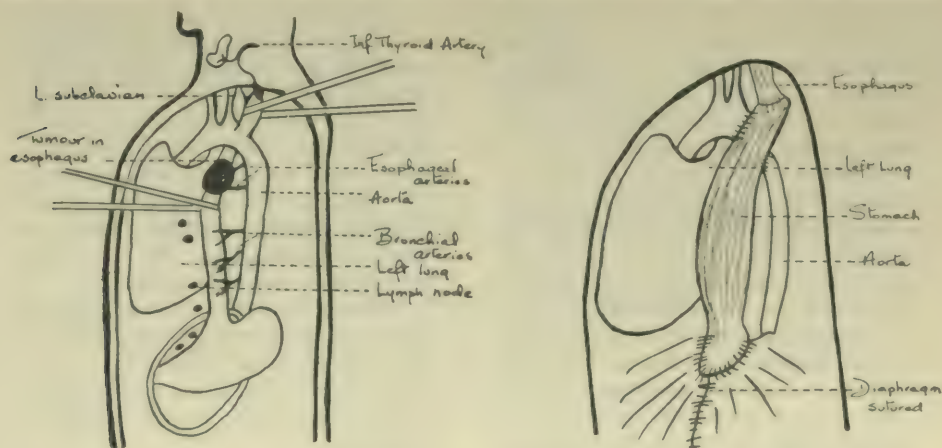
Mrs. Mann was allowed nothing by mouth after the noon meal on the day preceding the operation. The upper end of the esophagus was irrigated by means of a small catheter and a large syringe, using a sodium bicarbonate solution. This was done twice on the afternoon before and twice on the morning of the operation. An instillation of 125,000 units of aqueous penicillin in 10 cc. of saline was inserted into the esophagus following the irrigations.

The skin preparation consists of shaving the patient's entire chest from umbilicus up, including the axillae, as the site of the incision may not be definitely settled.

OPERATION

The anesthetic was endotracheal cyclopropane. An incision was made along the 7th left interspace and the chest was opened. The 8th rib was divided posteriorly. The lung was found to be free. The mediastinal pleura was opened longitudinally behind the pulmonary ligament and the esophagus exposed. A hard tumor was palpable, extending down the esophagus from the level of the aortic arch for a distance of about 8 cm. The esophagus was closely adherent to the superior pulmonary vein, the arch of the aorta, and the right main bronchus. It was separated from these structures. The diaphragm was then opened from the esophageal hiatus to the anterior chest wall, and the stomach prepared by dividing the gastric arteries and the gastroduodenal omentum down almost to the duodenum. The left gastric artery was then ligated and divided close to its origin, freeing the stomach so that it could be brought well up into the chest. The stomach was divided close to the cardiac end and the stump closed. The stump of the esophageal end was left clamped.

In order to get more exposure the 7th, 6th, and 5th ribs were divided along with their intercostal bundles. The esophagus was then brought out above the arch of the aorta. The stomach was pulled up into the chest and was found to



reach two inches above the arch of the aorta, but under considerable tension. The stomach was anastomosed to the esophagus about 3 cm. above the aortic arch. The diaphragm was sutured about the stomach wall so as to relieve tension on the suture line, leaving a hiatus about $1\frac{1}{2}$ inches in diameter. The remainder of the diaphragmatic opening was then sutured. The chest was irrigated with normal saline, sucked dry, and the anastomatic area powdered with a sulfathiazole-penicillin mixture. The chest was then closed. An intercostal catheter was left in the anterior end of the wound and attached to an underwater tube which allowed fluid to drain from the chest and did not allow air to enter the thoracic cavity. Dry dressing was applied firmly. The patient was placed on her back with the foot of the bed elevated about 12 inches. Following her return to the ward, Mrs. Mann's condition became rather poor but she responded well to transfusion and intravenous therapy. Her blood pressure was 98/50 due partly to shock from the operation which took seven hours.

POST-OPERATIVE CARE

December 20: On return from the operating-room Mrs. Mann was placed in an oxygen tent in order to relieve dyspnea. The water and electrolyte content of the body was maintained by the intravenous administration of 5% glucose in water. The underwater drain was checked immediately to make sure it was fluctuating with her breathing and draining well. Mrs. Mann's position was

changed every two hours and she was encouraged to cough to prevent a mucous plug from forming.

December 21: The foot of the bed was lowered and she was taken out of the oxygen tent for four hours. Twelve ounces of sanguinous fluid had drained. Her condition was fairly good; she was slightly pale but not cyanosed. Breath sounds were good throughout both lungs. She was turned frequently and encouraged to cough every hour to prevent any lung complications. X-rays showed the left lung well re-expanded. There was a small amount of fluid at the right base and a partial atelectasis in the right lower lobe. Mrs. Mann was taking only sips of water by mouth. An intravenous of 1,000 cc. of 5% glucose in saline was given with 500 mgm. vitamin C added. Her blood pressure was 125/80; pulse 98, of good quality.

December 22: Mrs. Mann was slightly pale and cyanosed. Her respirations were labored and pulse rapid—120; blood pressure 105/80. She was placed on the seriously ill list. A hemoglobin test was done and this was 110. X-rays showed considerable distention of the stomach in the left chest with a slight shift of the mediastinum. This was causing the labored respirations. A transfusion of 800 cc. of plasma was given followed by 1,000 cc. of glucosaline. A small Levin tube was passed into the stomach and a considerable quantity of old blood and gas was aspirated. The stomach was then suctioned for one hour every four hours.

December 23: Her condition was slightly improved. Blood pressure 130;

pulse 110-120. Air entry was good in both lungs. The stomach was not quite so distended. She was having difficulty bringing up tenacious sputum. Clear fluids were taken by mouth and she was given another 1,000 cc. of glucosaline.

December 24-26: Mrs. Mann was improving. She was taking one to two ounces of clear nourishing fluids every half-hour. This included the whites of two cooked eggs cut up fine and added to her drinks. The Levin tube with suction was inserted twice a day—in the morning and at bedtime. Mrs. Mann found the tube very disturbing so it was removed after half an hour. Her position was changed every two hours. She remained in the oxygen tent most of the time as her respirations were still labored. She was able to cough up a moderate amount of phlegm.

December 27: Color was good, no dyspnea. She was coughing up clear sputum. The right lung was clear except for a few râles at the right base. The left lung was clear at the apex. She was taking nourishment well.

December 28: A special protein mixture "Essenamaine" was added to the clear fluids. She was receiving 1,000 cc. of 5% glucose in saline daily. X-rays showed the left upper lobe was well expanded with a distended stomach in the left chest. There was very little shift of the mediastinum. There was evidence of pneumonitis in the right lung.

December 31: Mrs. Mann was taking vitamins by mouth. The oxygen tent and gastric suction were discontinued.

January 3: She was feeling much better. The drainage tube and sutures were removed. The wound was well healed. Air entry was good throughout the right lung. No adventitious sounds were heard. She was on a diet of fruit juices, strained soups, and junket.

January 7: X-rays showed the base of the right lung had cleared. The stomach was distended with gas and about half filled the left chest. There was very little residual fluid in the stomach, showing that it was emptying properly. Mrs. Mann was feeling well apart from the pain, due to cutting of the ribs at operation in her left chest, which was gradually diminishing. She was taking nourishment well without distress.

January 9: A soft diet was given in small quantities every hour during the day. The diet was high in iron.

January 20: Mrs. Mann was discharged from hospital. She was to remain on a soft diet.

SUMMARY

In carcinoma of the lower third of the esophagus, of the esophago-gastric junction and of the cardiac portion of the stomach, the operation of transthoracic esophago-gastrectomy is the treatment of choice. By this method it is possible to remove the disease and to restore the continuity of the alimentary tract by an esophago-gastric or esophago-jejunal anastomosis.

The most important points in nursing care include the following:

1. Pre-operatively the diet must be of high caloric value and usually has to be forced since the patient will have difficulty in swallowing.
2. Immediately post-operatively, the patient's position must be watched to allow for proper drainage and good breathing. She must be turned every two hours and encouraged to breathe deeply in order to keep the lungs well expanded.
3. The patient must be encouraged to cough frequently in order to prevent an atelectasis from occurring.

Handbook on Poliomyelitis

As of March 1, 1950, a charge of 35 cents per copy will be made for the 88-page handbook, "Nursing for the Poliomyelitis Patient," published in 1948. Sale of this publication is limited to nurses, physicians, physical therapists, and members of allied

professional groups—in accordance with policies of the medical department of The National Foundation for Infantile Paralysis. Orders should be sent to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York City 19.

Public Health Nursing

The University's Part in Planning a Student Program

JENNY M. WEIR, B.Sc., M.A.

Average reading time — 6 min. 24 sec.

PLANNING THE FIELD program for students at Queen's School of Nursing involved consideration of:

1. The course offered by the School; the background of the students enrolled; the objectives of the courses; time-table restrictions.
2. The objectives of field observation and experience.
3. The facilities available for field observation and experience.

Queen's School of Nursing offers two *types of courses*—a five-year course leading to a Bachelor of Nursing Science degree, with either public health nursing or teaching and supervision being chosen as the specialty in the final year; and a diploma course for graduate nurses, a one-year course, in either specialty. The objective of the courses is to prepare nurses for first-level staff positions in public health nursing or teaching and supervision. This preparation should involve developing in the student enthusiasm for the chosen field; providing the students with a body of knowledge which they know how to use; and helping them to develop an awareness of their limitations and how these limitations can be reduced by use of community resources. Regardless of the field, all final year and diploma students take the course in Principles of Public Health Nursing and the field observation trips. The

teaching students are included to aid them in their future teaching of the preventive concept in schools of nursing.

Nursing students take a number of lectures and laboratories with students of other schools and faculties. This has advantages. The students come in contact with a wider field of interest through discussion with people in other interest groups. However, one disadvantage is that the field program during the year must be planned with time-table restrictions in mind—restrictions dictated by larger sections of the university. So far, this has not proved a great disadvantage. Blocks of field experience are planned prior to and following the academic year. There are also spaces in the time-table suitable for field visits.

The objectives of field observation and experience are:

1. To round out experience
2. To provide an opportunity to apply theory.
3. To observe and utilize community resources.

It would be difficult, if not impossible, for a school of nursing to realize their objective of preparing nurses for first-level staff positions without field observation and experience. The success of a public health nurse can be measured by her ability to apply theory. The success of a university course to prepare public health nurses could be measured by the same standard. Therefore, part of the university's responsibility is to

Miss Weir is lecturer in public health nursing and acting director of the School of Nursing of Queen's University, Kingston, Ont.

realize the importance of the field program to the student and the standards of the school.

Facilities available for field observation and experience: A university school of nursing has as its primary purpose the preparation and education of students. Public health nursing agencies and other community resources do not have this as a primary purpose. They have their service to the community to consider first. There are advantages to be gained by the agencies from student visits or affiliation. The university should try to be aware of agency problems. Conferences between agencies and the school faculty may bring some of these problems to light. The agency may be so keen to assist that they do not give a true picture of difficulties. One of the ways to overcome this is for the school faculty to keep from getting so far away from practical experience that they forget the problems of service.

The writer had a very worthwhile experience last spring. The Ontario Division of Public Health Nursing planned a period of field observation for her. She spent two weeks with the Brant County health unit. Being back in the field highlights again the many demands made on an agency for field work, as well as showing new developments in operation.

How was the student field program for Queen's School of Nursing planned? What is at present offered? What is the hope for the future?

In the first year of the degree course the students are introduced to the preventive concept by a course of lectures, including personal hygiene and an introduction to community health. Visits to community resources reinforce these lectures. These visits are not meant to duplicate the visits they will make later in their hospital experience and are, therefore, planned with that in mind.

During the three years of training, field observation is determined by the school of nursing in which the student takes her training. Queen's School of Nursing must approve the choice of the school made by the

student. An attempt is made to have the students enrol where the preventive concept is taught throughout training. This is one difficulty yet to be overcome.

Prior to the final year's work the public health nursing students must complete a period of four weeks' observation with the Victorian Order of Nurses. A period of employment with this Order is counted in place of the field experience. A report of the field experience or employment is sent to the school by the V.O.N. This prerequisite to the final year or diploma year helps to make up lacks in the students' background as well as create enthusiasm for the chosen field. We would like to see this experience extended to include our teaching and supervision students. The needs of our school in this field of student affiliation are easily met by correspondence and discussion with the chief superintendent of the V.O.N.

Field visits during the final degree year and the diploma year are meant to supplement the lectures in Preventive Medicine and Principles of Public Health Nursing. Queen's University occupies an enviable spot in the community. This regard was very valuable when we came to plan field visits. Discussion with the medical officer of health for Kingston indicated visits he planned for the medical students. These served as a guide until a knowledge of the community was gained.

Field observations during the year are planned with the co-operation of the director of public health nursing for the city of Kingston. She and her staff give us excellent support in child welfare, school work, and chest clinic observation. It is hoped these observations can be extended to include industry and social agencies. Shortages of trained staff have meant delay. The students do get valuable observation of the co-operation of social agencies in their attendance at mental health clinics. Kingston has a centre for the boarding-home care and study of children with serious emotional problems, making foster home placement or adoption difficult.

The work done by this centre gives the students an excellent idea of the co-operative effort of mental hygienist, social worker, psychologist, school teacher, public health nurse. Weekly conferences to discuss problems are held.

These are some of the ways in which throughout the year the students are helped to see the application of theory. How about their opportunity to apply the theory in the field? This is given in the spring, following the close of lectures. Discussion of the students' needs with the educational supervisor of the Division of Public Health Nursing of the Ontario Department of Health precedes the placing of students for a four-week term of experience with an official agency. The process seems so

simple that the university might easily forget the planning which has gone into zoning Ontario so that the several universities may have a share in the available field experience.

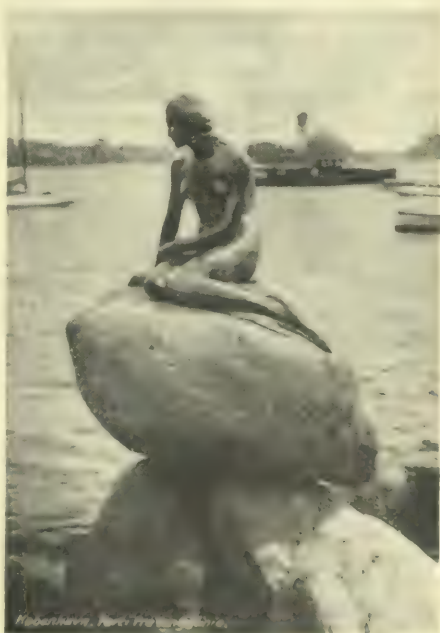
This program is not static. It grows from year to year. The university's part in planning this program includes: Outlining the needs of the students; learning the community facilities to *supplement* the university program (the student should go into the field as well prepared as possible—the agencies should not be expected to make up all the lacks in the students' background); contributing in any way possible to the community health and welfare program. Student affiliation can be a learning experience for the teacher as well as the student.

International Group Excursion in Denmark

Though it is hoped that most Canadian nurses who are travel-bent next summer will be going to the C.N.A. convention in Vancouver, for those who are planning a trip to Europe the announcement of the Danish Council of Nurses will hold interest. They are planning for a special course on "Tuberculosis Care and Treatment, Especially in Relation to the Prevention of Tuberculosis and to B.C.G. Vaccination."

Copenhagen will be the centre of the studies from *June 11 to June 24*. Through lectures, which will be in English, visiting nurses will be made acquainted with social care and tuberculosis treatment in Denmark. In addition, excursions will be arranged to various institutions in Zealand, such as sanatoria for grown-ups and for children, seaside hospitals and sanatoria, convalescent homes and "Christmas stamp" homes.

The expenses involved will be Danish kr. 300 (£15). This amount includes the cost of board, lodging, and all excursions and lectures. The Danish Council of Nurses will provide accommodation. The final date for application is **April 15**. Write to the *Canadian Nurses' Association, 1411 Crescent St., Montreal 25*.



The Mermaid—Copenhagen

Aux Infirmières Canadiennes-Françaises

Assurances Sociales

SUZANNE GIROUX

Lecture — 12 min. 48 sec.

DE TOUT TEMPS le public s'est intéressé à son bien-être, mais depuis ces dernières années une association plus étroite s'est faite dans les esprits entre la santé et le bien-être.

Tous les jours les journaux, sachant combien les gens sont avides de ce genre de nouvelles, rapportent des découvertes sensationnelles de la médecine et de la chirurgie et des guérisons qui tiennent presque du miracle. Rayons-x, poumon d'acier, reins artificiels et radium sont des termes familiers pour le plus profane de la médecine.

Ce pauvre corps, si dédaigneusement traité par les moralistes de jadis, est devenu l'objet d'une grande attention. On en prend presque aussi bien soin que de son auto et l'on va chez le médecin, à l'hôpital une à deux fois l'an pour faire vérifier si tout va bien. Les moins prévoyants se hâtent, dès les premières manifestations de la maladie, de faire de même, espérant entraver à temps le mal qui se fait sentir. Or, depuis que le public est plus conscient de la valeur de la santé, il a envahi (prit presque d'assaut) nos hôpitaux.

Les riches, en ceci comme en tout le reste, obtiennent tout ce que l'argent peut procurer et partant tous les soins même les plus coûteux que leur santé peut réquerir. A l'autre extrémité de l'échelle sociale, les indigents jouissent d'avantages presque comparables, grâce à la charité professionnelle et à l'assistance publique, au moins pour ce qui a trait à l'hospitalisation.

Pour ces deux classes de la société donc rien de changer, mais pour la classe moyenne les assurances contributives du type de la Croix-Bleue ont certainement été d'un grand bienfait et, dans bien des cas, d'un grand secours.

Chacun sait quelle catastrophe peut être pour ces foyers la maladie grave du père ou de la mère et souvent quel problème économique peut représenter l'appendicite de la cadette ou la simple ablation des amygdales du petit dernier.

Malgré le bienfait de ces assurances, tout le public ne peut en bénéficier. Certaines familles ont de lourdes charges et le salaire suffit à peine à subvenir aux nécessités de la vie.

Ces gens, comme bien d'autres, trouvant onéreux de payer des assurances, des frais d'hôpitaux, se tournent du côté de l'état et demandent une plus grande sécurité sociale en matière de santé. Si d'une part le public se tourne du côté de l'état, on voit d'autre part les hôpitaux se diriger du même côté et demander une assistance financière.

La guerre, la perception des impôts sur les revenus et sur les successions ont diminués les grandes fortunes. Les dons aux hôpitaux se font de plus en plus rares et moins généreux. Il en résulte que les déficits des hôpitaux ne sont plus comblés et aussi une augmentation dans le coût de l'hospitalisation; 87 pour cent des revenus de l'hôpital proviennent des malades. Le malade ne peut payer davantage et, sans augmenter ses charges, l'hôpital voit son déficit grossir d'année en année. L'hôpital et le malade sont pris dans un cercle vicieux dont ils ne peuvent sortir sans une aide.

Mlle Giroux est visiteuse officielle pour les écoles d'infirmières françaises de la province de Québec.

D'où viendra cette aide? On a vu que l'on ne peut plus beaucoup compter sur la charité privée; la charité professionnelle doit aussi par la force des choses se limiter.

L'état deviendra-t-il le bras droit de la Providence et assurera-t-il à chaque citoyen la sécurité sociale dont il a besoin en maladie? L'état c'est nous—en démocratie, le peuple. Quel nouvel impôt aurons-nous à payer pour arriver à cette fin? La liberté et la dignité humaine veulent-elles que l'état devienne l'administrateur de nos économies en cas de maladie, comme il l'est déjà pour les accidents du travail et pour les chômeurs?

Avant de résoudre ce problème philosophique, voyons un peu ce que l'on entend par les expressions si couramment employées—sécurité sociale, médecine sociale, assurance-santé, etc. J'emprunte au Dr. Jules Gilbert, directeur de l'enseignement de l'hygiène au Ministère de la Santé et sous-directeur de l'école d'hygiène de l'Université de Montréal, les définitions suivantes:

La sécurité sociale est un système collectif de protection contre certains risques et certains besoins qui dépassent les moyens de la majorité des individus. Dans ces risques ou besoins entrent les principaux hasards de la vie qui privent la famille de son moyen de subsistance—que ce soit le décès, le chômage, ou l'invalidité, et que celle-ci soit due à la maladie, à l'accident, à l'infirmité, ou à la vieillesse.

L'assistance sociale a pour but de soulager ces malaises sociaux, mais sur une base de compassion et de charité. C'est une aide gratuite, découlant du soi-disant paternalisme de l'état, d'ordinaire réservé aux groupes de la population classés comme indigents et à bas revenus.

La médecine sociale se distingue facilement de la médecine privée dans sa forme traditionnelle, que tout le monde connaît. C'est un mode de distribution des soins médicaux, organisé de manière à satisfaire les besoins réels de la société, indépendamment de la capacité de paiement des malades. Il est basé sur ce principe que le manque d'argent ne

doit pas être une entrave au recouvrement de la santé. C'est là évidemment une préoccupation d'ordre social, qui cherche à promouvoir le progrès national par la conservation d'un bien infiniment plus précieux que la richesse—le capital humain.

L'assurance médicale: Lorsqu'une forme de contribution fixe ou variable, individuelle ou familiale, est prélevée pour le financement du système, cela devient de l'assurance médicale. Remarquons que la taxe spéciale, la cotisation, la prime, le droit d'enregistrement, etc., ne sont que divers modes de contributions en vue d'accumuler un fonds commun pour défrayer le coût des soins qui seront requis par ceux qui tomberont malades. Quand l'assurance est libre dans une entreprise commerciale ou non-lucrative, on la dit *volontaire*; quand elle est généralisée par décret à toute la population, on la dit *obligatoire*. (C'est le mode existant actuellement en Angleterre et dans notre pays en Colombie-Britannique et Saskatchewan.)

Si les services ne sont rendus qu'aux individus devenus malades, c'est évidemment *l'assurance maladie*. Si les bénéfices ou prestations sont restreints aux malades hospitalisés pour leur traitement, on a alors *l'assurance hospitalisation*. Mais lorsque, au lieu de se limiter au traitement de la maladie déclarée, le système offre à titre de bénéfices des services de nature préventive pour la conservation de la santé, alors et seulement dans ce cas peut-on parler d'*assurance-santé*.

En 1944, le parlement approuva le rapport Heagerty lequel préconisait l'institution d'un régime obligatoire contributif d'assurance-santé au Canada. En Angleterre, le rapport Beveridge a amené l'établissement d'assurance-santé.

Aux Etats-Unis, plusieurs initiatives du gouvernement font prévoir que l'assurance-santé fera partie du programme de sécurité sociale de ce pays. Au Canada, deux de nos provinces, l'Alberta et la Saskatchewan, ont des formes d'assurance-santé. Où en sera notre pays dans cinq ans, dans dix ans d'ici?

Actuellement il se poursuit à travers tout le Canada une enquête rela-

tive, dit-on, au projet de l'établissement d'une assurance-santé. Dans chaque province on fait le relevé des ressources et des besoins, hôpitaux existants, hôpitaux à construire, service d'hygiène à créer ou à développer, formation du personnel, etc. Quel sera le résultat de cette enquête? Devant les besoins, présumés considérables de notre population, se hâterait-on de construire des hôpitaux sans trop s'inquiéter de la valeur du personnel donnant des soins aux malades? Ou, au contraire, s'assurait-on le concours d'un personnel bien qualifié pour conduire à bonne fin un programme de santé à la portée de toute la population de la province, qu'elle soit urbaine ou rurale?

Chose certaine, deux points importants semblent à l'ordre du jour—la nécessité de diriger nos efforts vers la prévention et la nécessité de former un personnel compétent.

En viendra-t-on dans notre pays à l'établissement prochain d'une assurance-santé nationale, contributive, obligatoire? Quelle sera la répercussion de ce projet si jamais il se réalise? Certainement une meilleure santé et peut-être un plus grand rendement économique. Espérons que ce paternalisme de l'état n'amointrira pas chez-nous les vertus de force, de prudence, de tempérance, et de justice sur lesquelles s'appuie toute grande nation.

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Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Florence I. Greenaway* (Toronto Western Hosp.; University of Toronto School of Nursing; B.N., McGill University) has joined the staff of the Division of Public Health Nursing. Her experience includes staff work and supervision with the V.O.N. as well as in the official field. She was supervisor of public health nursing with the Bruce County health unit during the first two years of its development.

With the annexation of the townships of Nepean and Gloucester to the city of Ottawa, *Ina Dickie* (Hamilton Gen. Hosp. and University of Western Ont. certificate course and U. of T. advanced course in administration and supervision), who has been supervisor, Carleton health unit, has been appointed to the supervisory staff of the Ottawa board of health. *Anna MacFarland* (Children's Memorial Hosp., Montreal, and McGill University public health course) and *Hazel Wilson* (Ottawa Civic Hosp. and McGill U. p.h.n. course) have also transferred to the Ottawa board of health. *Jennie Aris* (Barton Hep-

burn, Hosp., Ogdensburg, and approved school nurse cert. summer course, Ont. Dept. of Education) has rejoined the public school service of Nepean Township.

Dorothy (Boyd) Johnston (U. of T. diploma course) as senior public health nurse, Woodstock; *Dorothy (Morgan) Lang* (St. Joseph's Hosp., Toronto, and U.W.O. cert. course), formerly with Huron County health unit, to Etobicoke Township board of health; *Jean McArthur* (Toronto Gen. Hosp. and U. of T. general course) to York Township board of health; *Rose-Idele Pilon* (Ottawa Gen. Hosp. and University of Montreal p.h.n. course) to Prescott and Russell health unit; *Marian (Higginson) Ransden* (Toronto Western Hosp. and U. of T. gen. course), formerly with Halton County health unit, to Ottawa board of health; *Maude Reesor* (St. Catharines Gen. Hosp. and U. of T. gen. course) to East York-Leaside health unit.

Resignations: *Jean Johnston* from Etobicoke Township board of health; *Gladys (Neal) Owen* as public health nurse, Espanola; *Lottie (Muir) Wilson* from East York-Leaside health unit.

Trends in Nursing

Average reading time — 8 min. 48 sec.

The Registrars' Conference

On November 7 and 8, just prior to the Executive Committee meeting of the C.N.A., the registrars from across Canada met at our headquarters in Montreal to discuss common problems.

The members present were: The eight provincial executive secretaries, Prince Edward Island only being absent; director, Nurse Registration Branch, Ontario; chairman, Committee on Educational Policy, C.N.A.; president, Registered Nurses' Association of Nova Scotia; editor and business manager of *The Canadian Nurse*; two National Office secretaries and the Canadian Nurses' Association's statistical worker. The sessions were chaired by the general secretary, Gertrude M. Hall. Agnes Macleod acted as secretary for the conference.

After welcoming the group, Miss Hall paid a moving tribute to Miss Upton, who had attended the previous registrars' conference and whose comradeship we all sadly missed.

The first item of business was a review of the resolutions resulting from the last conference in December, 1947. This resulted in a province by province report on:

1. Any modifications that had been made in educational requirements for admission to schools of nursing
2. Extent of use being made of psychometric tests.
3. Recommendation that each provincial association set up a committee to which students, who had resigned but wished to enter another nursing school, might turn for advice.
4. Modification of educational requirements for reciprocal registration.
5. Interest in or use made of the suggested uniform application form.

Miss Hall reported on the action taken on two additional resolutions.

Muriel Archibald discussed methods of obtaining statistical data and

Marion Nash explained the procedure followed in drawing up the booklet on Salary Schedules.

On the first afternoon we were privileged in hearing from Sister Denise Lefebvre a scholarly presentation of the evaluation program in schools of nursing, with emphasis on preparation and procedures for the visit to the school and preparation for the report.

Margaret Street shared with us her experiences in attending a work conference on the accreditation program held in New York last August.

A lengthy and very helpful discussion occurred on the problems connected with reciprocal registration for nurses from European countries, in particular those nurses brought to Canada under contract from displaced persons camps.

Miss Nash discussed methods of publicizing the work conferences, enlisting the co-operation of the provincial secretaries in interpreting to our members the purpose and value of this form of study.

The last item on the agenda was one which we will all remember—Miss Hall's account of the National Secretaries Conference held in Sweden.

The registrars were guests of the C.N.A. at an informal luncheon at the Business and Professional Women's Club on Monday and of the Association of Nurses of the Province of Quebec at a luncheon in the Vice-Regal Suite of the Ritz Carlton Hotel on Tuesday. Both were most enjoyable events.

From the Registrars' Conference, the following resolutions were submitted:

1. WHEREAS, It is helpful to provincial associations to know the nature and extent of difficulties encountered by their nurses in respect to reciprocal registration; therefore be it

Resolved, That the Canadian Nurses' Association request that each provincial

registrar notify the appropriate provincial office in each instance that a Canadian nurse is found to be ineligible for registration in another province.

2. WHEREAS, In general education, it is accepted policy to provide each student with an official statement of the content of course completed; and

WHEREAS, Nurses upon graduation frequently are required to submit a record of their training for educational and/or registration purposes; therefore be it

Resolved, That the Canadian Nurses' Association recommend to the provincial nurses' associations that schools of nursing be urged to supply to each nurse upon graduation an official transcript of her nursing course, including theory and practice.

3. WHEREAS, The Canadian Nurses' Association has endorsed the principle of evaluation and accreditation of schools of nursing; and

WHEREAS, There is a need to interpret the purpose and value of an evaluation and accreditation program both within and without the profession; therefore be it

Resolved, That as necessary first steps:

(a) A series of articles on the subject be published in *The Canadian Nurse*.

(b) It be suggested to provincial nurses' associations that programs for annual meetings within the next year include an interpretation of evaluation and accreditation.

(c) The Canadian Nurses' Association recommend to provincial associations that regional conferences on this topic for schools of nursing administrators be arranged.

4. WHEREAS, The C.N.A. Executive passed a resolution in 1936 urging all university schools and departments of nursing to standardize the requirements for admission to the same level as that required by all other faculties and departments; and

WHEREAS, There are many experienced senior nursing personnel whose educational qualifications debar them from enrolment in these schools or departments of nursing for advanced work in such fields as administration, supervision, etc.; therefore be it

Resolved, That the Council of University Schools and Departments of Nursing be approached with a view to making a study of the situation in the hope of finding a possible solution that would be applicable in individual instances.

5. WHEREAS, The policy of setting salaries for hospital nurses in terms of a stated amount plus maintenance results in a faulty conception of the actual remuneration received and, where part of the nursing staff does not live in residence, penalizes this latter group; therefore be it

Resolved, That the Canadian Nurses' Association seek the co-operation of the Canadian Hospital Council in an endeavor to have all nurses' salaries established as gross salaries.

Exciting Times

From Delhi comes a report of a meeting of representatives from Afghanistan, Burma, Ceylon, India, Thailand, and French and Portuguese India, who met in the World Health Organization Regional offices to discuss health problems. The report states:

The discussion held amid stifling heat in a tiny conference room would have seemed to an outsider rather unexciting. Yet in a sense these three days were both exciting and sensational. They proved that four hundred million people, through their representatives, can meet on common ground, discuss problems, and reach decisions that aim at alleviating human suffering.

The decision to pool facilities for personnel training and for various types of research work was the first step of vital importance. The writer continues:

The needs are so vast and the men and women trained to do the work are so few in numbers that unprecedented international team-work is called for.

When we think of what the control of malaria and venereal disease would mean not only in improved health but in new ability to provide the wherewithal to sustain life, that is, to provide what we in this country take for granted—food for all to eat—we are convinced that nurses must

know what World Health Organization is attempting so that they can intelligently interpret the work of WHO and support it in every way possible.

The article mentions the second great need, medical supplies, without which the trained personnel can accomplish little. Currency devaluation has increased the difficulties as most drugs have to be imported. A survey has been requested to determine the needs of the individual countries and their existing resources in raw material, technical personnel, etc., so that, with facts at their command, "a comprehensive and co-ordinated plan for the development of local production facilities in strategic centres throughout the region" can be organized.

The promise—"liberation from the slavery of disease and misery"—for vast numbers of people is, as the article says, sensational. This promise cannot be fulfilled in a month or a year, but already some results are noticeable. It is well to remember that "health, like peace, cannot be

bought anywhere in the world at cut-rate prices."—*WHO Newsletter*, Oct. 1949.

Citizens' Forum

How many Canadians listen to "Farm Forum" and "Citizens' Forum"? This is a unique form of program, originating in Canada and not duplicated anywhere else in the world. Through provincial and national reports of Forum opinion, a two-way channel of communication is established. "The people on the broadcast panel don't have the last word on the subject. The listener, too, has an opportunity to air his views." This affords Canadians "a better means of bringing public issues home to people, of helping people find solutions to their problems and take action, than exists in any other country."

See *Food for Thought* (page 31) for information on how to form a discussion group. This booklet may be obtained from the Canadian Association for Adult Education, 340 Jarvis St., Toronto 2.

Orientation et Tendances en Nursing

LA CONFÉRENCE DES REGISTRAIRES

Le 7 et 8 novembre les registraires des associations provinciales d'infirmières du Canada se réunissaient en conférence, préalablement à la réunion du Comité Exécutif de l'Association des Infirmières du Canada, dans le but de discuter leurs problèmes communs.

Assistaient à cette réunion: Les secrétaires-registraires de toutes les provinces sauf celle de l'Île du Prince-Edouard; la directrice du département des infirmières du Ministère de la Santé de l'Ontario; la présidente du Comité de l'Éducation de l'A.I.C.; la présidente de l'Association des Infirmières Enregistrées de la Nouvelle-Écosse; le rédacteur du *Canadian Nurse*; les deux secrétaires et la statisticienne de l'A.I.C. Les séances furent présidées par Gertrude M. Hall et Agnes Macleod agit comme secrétaire.

Après un mot de bienvenue Mlle Hall rendit hommage à la mémoire de Mlle Upton, présente lors de la dernière assemblée des registraires.

Une revue des résolutions adoptées lors de la dernière assemblée des registraires en 1947 et des mesures prises depuis par chacune des provinces à cet égard fit l'objet de la première séance. Voici ces résolutions:

1. Changements survenus dans l'une ou l'autre des provinces concernant le degré d'instruction exigé pour l'admission à l'étude de la profession.

2. En quelle mesure les tests psychométriques sont employés.

3. Formation dans chaque association provinciale d'un comité chargé de donner des avis à une élève sortant d'une école d'infirmière et désirant entrer dans une autre.

4. Pour l'obtention de l'enregistrement par

reciprocité, tous changements des exigences en éducation dans les provinces.

5. Intérêt montré sur la proposition d'une formule d'enregistrement uniforme.

Muriel Archibald discuta des méthodes pour l'obtention de statistiques et Marion Nash expliqua la méthode employée pour la rédaction du livret sur les salaires.

Dans l'après-midi, l'assemblée eut le privilège d'entendre la Soeur Denise Lefebvre. Elle présenta un travail sur l'Evaluation des Ecoles d'Infirmières. Elle appuya sur la préparation et la marche à suivre lors de la visite d'une école et la préparation du rapport.

Margaret Street a assisté à une conférence d'étude sur l'Evaluation des Ecoles d'Infirmières, tenue à New-York en août dernier, à laquelle Soeur Lefebvre était également présenté et en fit rapport.

Une longue et très fructueuse discussion eut lieu sur les problèmes présentés par les infirmières des pays européens, particulièrement sur celles amenées au Canada des camps des personnes déplacées.

Mlle Nash discuta des méthodes de publicité afin de faire connaître les Conférences d'Etudes du prochain congrès biennal. Elle obtint la co-opération de toutes les secrétaires provinciales en expliquant aux membres la valeur de ces conférences.

Le dernier article au programme était un rapport de la réunion des secrétaires nationales tenue en Suède, lors du Congrès international des Infirmières. Le temps manquant, Mlle Hall n'a pu qu'effleurer le sujet.

Les registraires furent les invitées à un déjeuner de l'A.I.C. et de l'Association des Infirmières de la Province de Québec. Ces deux réceptions furent très agréables.

Les résolutions suivantes furent soumises:

1. *Etant donné* qu'il est très utile pour les registraires de connaître les difficultés que rencontrent les infirmières de leur province respective, lorsqu'un de leur membre demande son enregistrement dans une autre province, il est proposé que l'A.I.C. demande à chaque registraire provinciale d'aviser la registraire intéressée chaque fois qu'une infirmière ne peut obtenir son enregistrement par réciprocité.

2. *Etant donné* qu'en matière d'éducation il est d'usage de donner à chaque étudiante une attestation officielle du ou des cours suivis et le contenu de ces cours; et *étant donné* que fréquemment l'on demande aux

infirmières de présenter pour fin d'enregistrement et pour connaître la valeur de leur formation le détail de leur cours, il est proposé que l'A.I.C. recommande aux associations provinciales que l'on presse les écoles d'infirmières de remettre à chacune de leurs élèves, lors de leur graduation, une attestation de leurs cours d'infirmière, comprenant le détail de la théorie et de la pratique.

3. *Etant donné* que l'A.I.C. appuie le principe d'évaluer et d'accréditer les écoles d'infirmières; et *étant donné* qu'il est nécessaire d'interpréter aux membres de la profession, comme aux gens de l'extérieur, le but et la valeur de l'évaluation et de l'accréditation, il est donc proposé d'aller de l'avant:

(a) En publiant une série d'articles sur le sujet dans le *Canadian Nurse*.

(b) Que dans les assemblées générales des associations provinciales, l'on mette au programme l'interprétation de l'évaluation et de l'accréditation des écoles.

(c) Que des conférences régionales sur ce sujet soient données aux administrateurs d'écoles d'infirmières.

4. *Etant donné* que, dès 1936, l'A.I.C. a demandé aux universités, ayant une école d'infirmières, d'uniformiser le degré d'instruction exigé à l'admission et que ce degré soit le même que celui exigé pour les élèves admis aux autres facultés; et *étant donné* que plusieurs infirmières, dont l'instruction n'atteint pas le niveau exigé, sont empêchées du fait de se qualifier comme administratrice, surveillante, etc., il est donc proposé que cette question soit étudiée avec les universités afin de trouver une solution à ce problème.

5. *Etant donné* que la politique adopté par les hôpitaux de déterminer les salaires des infirmières comme salaire net, plus le logement et la pension, a pour résultat de donner une idée fausse des salaires payés aux infirmières; et *étant donné* qu'une grande partie des infirmières, vivant en dehors de l'hôpital, ne bénéficient pas des avantages du logement offert par l'hôpital, il est donc proposé que l'A.I.C. demande la co-opération du Canadian Hospital Council afin que les salaires des infirmières soient déterminés comme salaire brut.

UNE NOUVELLE SENSATIONNELLE

De Delhi, l'on nous rapporte que des représentantes de l'Afghanistan, de Burma, de Ceylan, de l'Inde, de Thailand, et des Indes françaises et portugaises se sont réunies dans

les bureaux de l'Organisation Mondiale de Santé pour discuter des problèmes de santé.

Durant trois jours l'on exposa les problèmes et l'on détermina les dispositions à prendre pour venir en aide aux quatre cents millions d'habitants de leur pays.

Le contrôle de la malaria et des maladies vénériennes aurait un bon effet à la fois sur la santé et sur l'économie du pays. Ces malades rendus à la santé seraient autant de travailleurs pouvant gagner la vie et assurer à chacun le pain quotidien, que dans nos pays nous prenons pour acquis, oubliant que dans les Indes tous les jours des gens meurent de faim.

Un autre grand problème est la formation du personnel pour des travaux de recherches. Les besoins sont si grands et les moyens si restreints que l'on décida de mettre en commun toutes les ressources dont l'on dispose pour l'entraînement du personnel.

Le manque d'approvisionnement médical constitue un autre grand problème. La déva-

luation de la monnaie est aussi une entrave sérieuse, étant donné que presque tous les médicaments doivent être importés.

Malgré les ressources limitées l'on voit déjà des résultats satisfaisants. Il faut se souvenir que la santé, comme la paix, ne s'acquiert pas sans qu'il en coûte.—*Communiqué de O.M.S., Oct. 1949.*

AVEZ-VOUS PRIS PART AU DÉBAT?

Combien de canadiens écoutent les programmes de radio—"Farm Forum" and "Citizens' Forum"—où un groupe de citoyens discute d'un sujet d'actualité? Non seulement les personnes prenant part au programme ont le droit de dire leur mot, mais les personnes à l'écoute peuvent faire de même. Souvent la solution du problème est trouvée, grâce à la contribution d'une personne à l'écoute.

Ces programmes sont au moyen bien démocratique d'étudier une question. A la page 128 du *Canadian Nurse* de février l'on vous montre la valeur de ces programmes.



Much has been written in the past three months on the work conferences to be held during the Biennial Convention of the C.N.A., June 26-30, 1950. You know when and where they are to be held and have a pretty good general idea of conference procedure but little has been said to date on the methods you may use to make known your needs.

The Program Committee has been busy planning for several months and can now outline for you the general offerings. To simplify registration because we expect upwards of one thousand nurses will journey to Vancouver, your committee has drafted a registration form which will be available through your provincial offices. On this form you will find the titles of the various work conferences.

Preceding each title, a neat little box stands waiting to receive a number. Place numbers as indicated below in three boxes in the order of your preference, fill out the form in triplicate, retain one copy for your own information and return the other two, together with your registration fee, directly to *National Office, Suite 401, 1411 Crescent St., Montreal 25, Que.*

For example, if your first choice is Work Conference No. 1, indicate with the numeral one in the first box; if your second choice should be No. 3, place the numeral two in box three; and if No. 7 is your third choice indicate by placing the numeral three in box seven. Registration for each conference is limited to 50 and applicants will be registered in the order

in which the registration forms are received in National Office.

- ☒ 1. Evaluation and Accreditation of Schools of Nursing.
- ☐ 2. Job Analysis of Nursing Services.
- ☒ 3. Meeting the Total Needs of Long-Term Patients.
- ☐ 4. Methods of Evaluating Student Progress.
- ☐ 5. Counselling and Guidance
- ☐ 6. Staff Education.
- ☒ 7. The Nursing Team.
- ☐ 8. The Nurse in Industry.
- ☐ 9. L'Equipe en Nursing.
- ☐ 10. Student Work Conference.

In the February *Journal* you were given an opportunity to study the outline for the conference on Evaluation and Accreditation of Schools of Nursing. This month we present an overview of **The Nurse in Industry**. You have only to glance at the personnel of this consulting group to know that the conference will offer to *industrial nurses* such an opportunity as is seldom available for a study of problems faced every day by industrial nurses in their work with Canadian people.

WORK CONFERENCE—THE NURSE IN INDUSTRY

Consultants: Dorothy Percy, chief supervisor of nurses, Civil Service Division, Department of National Health and Welfare; Sarah Wallace, consultant, Division of Industrial Hygiene, Ontario Department of Health; Mildred Walker, senior nursing consultant, Industrial Health Division, Department of National Health and Welfare; Lorraine Miller, student adviser, Victorian Order of Nurses, Vancouver; Grace Hyndman, supervisor of social welfare services, Civil Service Health Division, Department of National Health and Welfare.

General objective: To acquaint nursing generally with the special contribution which may be anticipated from industrial nurses and ways in which the profession can best contribute to the development of industrial nurses in their health program.

Work conference aim: A consideration of industrial nursing in relation

to the total nursing picture, with special emphasis on ways in which industrial nurses and the profession as a whole can contribute to each other's effectiveness in the broad health program.

Overview: Effective adaptation of nursing skills to the industrial setting creates new problems, new emphases. These in turn equip the industrial nurse to make a unique contribution to nursing and, as well, point up her need for special assistance and understanding from the profession. Bearing in mind this "two-way flow"—the industrial nurse's opportunity to contribute to the profession and her special needs which must be met by the profession—the following topics are suggested:

1. *The industrial nurse as an integral part of the community health team.* The number of nurses supervising the health of gainfully-employed persons at their place of work has multiplied greatly as a result of increased industrialization and greater appreciation of the importance of good health as a contributing factor in production. The activities of these nurses can be most effective when synchronized with all other health and social forces in the community. How may this be accomplished?

2. *Employee health teaching and general counselling.* A discussion of scope, media, methods, and results. Industry affords the nurse a unique opportunity to work with the employed heads of families and, through them, to reach the homes.

3. *Techniques and procedures.* The industrial nurse adapts her nursing skills to meet new and special demands in industry in the fields of treatment, prevention, and environmental sanitation. How does she get assistance from her profession and elsewhere in the improved adaptation of these skills? What does industry contribute in this area? How does the nurse channel back those developments which might be of value in other nursing situations? Would professionally recognized standards for industrial nursing strengthen the industrial nurse in discussions with management regarding standing orders, medical direction, physical set-up, etc.?

4. *Employee and public relations.* Huge

sums are expended by industry to build effective employee and public relations. Industrial nurses have an important part in building friendly relationships within and without the plant. They are in an excellent position to observe the efficacy of various tested techniques. Might not some of these be used to advantage in nursing situations generally? What is the industrial nurse's responsibility for bringing these to the attention of the profession generally?

5. *The preparation of the industrial nurse.* A discussion of her academic, practical, and in-service training. What are the possibilities of a greater degree of exchange of field-work opportunities? What should be included in post-graduate courses for industrial nurses?

TRANSPORTATION

They are going by plane, they are going by train, and even by cabin trailer! Are you to be one of them? If so, you will be interested in learning what arrangements have been made to get you there. Turn to your October and February *Journals* for information on convention rates via Trans-Canada Air Lines.

If time must be conserved then this is the way you will want to travel but if the convention is to be a part of your holiday, you may prefer the more leisurely train journey. The Canadian Passenger Association has issued the following information regarding conditions on which convention fares will be granted on "The Standard Certificate Plan":

1. Reduced fares for the biennial meeting to those in regular attendance, including dependent members of their families.

2. (a) Persons attending must purchase one-way regular First Class, Intermediate Class, or Coach Class tickets (fare for which must be not less than 75 cents) to place of meeting (or nearest junction point); (b) Secure a receipt to that effect on Standard Certificate Form; (c) Present this certificate form to the secretary at the place of meeting on arrival.

3. *Have certificate validated* by special agent of the transportation company who will attend the meeting for the purpose.

4. (a) Surrender Standard Certificate Form properly filled in and executed to Ticket Agent at place where meeting is held at least *thirty minutes* prior to time train is due to leave; (b) Ticket must be of the same class as used on the Going trip.

5. (a) If secretary certifies that 75 or more are in attendance holding properly receipted certificates, holders of validated certificates will be returned to their original starting points at "*one-half*" of the one-way regular First Class, Intermediate Class, or Coach Class fare; (b) If there are 74 or less in attendance with validated certificates, the holders of such certificates will be returned to their original starting point at "*four-fifths*" of the one-way fare.

6. Return journey tickets are limited to 30 days after the date on which the ticket for the Going journey was valid for travel, as shown on the validated certificate.

7. Certificates will not be honored unless all the above requirements are fulfilled. Special attention is drawn to instructions under numbers 3 and 4 above.

ACCOMMODATION

The University of British Columbia has informed the Arrangements Committee of the C.N.A. that accommodation in the university area is available for approximately 1,000 conference delegates in two camps — Acadia Camp and Youth Training Camp.

1. (a) *Rates:* Rooms—\$1.50 per person per day. Meals served at camps at reasonable prices.

(b) *Accounts:* Delegates must pay for their rooms in advance. Meal tickets must be obtained at registration desk or at one of the camp offices.

(c) *Baggage:* See that baggage is plainly marked with name and address.

2. On arrival in Vancouver take a taxi to the camp to which you have been assigned—Acadia or Youth Training. Report to camp office where guides will be available to show you your room.

3. *Mail* to delegates should be addressed as follows: (a) Name; (b) Name of the conference being attended; (c)

University of British Columbia, Vancouver, B.C.; (d) Please include return address.

Hotel accommodation: Those wishing to stay downtown should make their own arrangements and should register early as hotel space is limited.

Nursing sisterhoods: Sisters desiring accommodation should indicate their

wishes on the regular forms. Five convents have offered accommodation for approximately 132 sisters; this number will probably be augmented. The cost per day has not yet been determined but it should not be excessive. Arrangements will be made for buses to and from the University of British Columbia.

Annual Meeting in New Brunswick

For the first time the Edmundston Chapter of the New Brunswick Association of Registered Nurses entertained the members of the association at their 33rd annual meeting, September 28-29, 1949. As Edmundston is at the very north of the province, the members had a very enjoyable drive up the Saint John River Valley or across country from Campbellton, Newcastle, Moncton, etc.

The meeting came to order at 9:30 a.m. The president, Hilda Bartsch, presided at all sessions. Monsignor W. J. Conway, of the Immaculate Conception Cathedral, offered the invocation, after which Mayor H. E. Marmen extended a very hearty welcome to the town of Edmundston. Representatives from all schools of nursing, all chapters, nearly all hospitals without schools of nursing, and student nurses from several hospitals answered roll call. Following the appointment of the Resolutions Committee and scrutineers the report of the Arrangements Committee was presented by Grace Stevens.

In her presidential address, Miss Bartsch reviewed the work of the past year which included amendments to the Registered Nurses' Act, passed at the 1949 session of the New Brunswick Legislature to become effective in January, 1950. She explained that provision was made for a register of student nurses to be kept in the provincial office; that a certificate of approval is to be issued annually to all schools meeting the requirements of the Act; and that it would now be possible to introduce provincial examinations at the end of the first year of training.

Miss Bartsch said a New Brunswick minimum curriculum had been completed which it is hoped would lead to more uni-

formity of teaching in the schools and enable them to complete the first-year subjects in the required time. She said considerable effort had been spent on getting Government support for nursing education and that a committee had been formed on Educational Policy. Referring to the re-opening of the School of Nursing at Dalhousie University, Miss Bartsch said this would be a possible source of qualified nurses for positions in the provincial hospitals.

Membership: The secretary reported a total membership for 1948 of 970 nurses on active duty; to August 31, 1949—1,006. Thirty applicants were awarded reciprocal registration.

The need for a full-time *school visitor* has been felt for some time. The N.B.A.R.N. has been considering ways and means of providing for such a person but, as provincial finances did not permit the venture, it was decided to request assistance from the Federal Grant. Our request was reported received but at the time of the annual meeting we were not sure of the outcome. (Since then we have been assured that assistance for this project is forthcoming.)

The *revised By-Laws* were presented by the convener of the committee, Miss I. Lane. Annual membership fees were raised from \$5.00 to \$10.00 which now includes affiliation fees of \$2.00 to the Canadian Nurses' Association and the International Council of Nurses, and a subscription to *The Canadian Nurse*.

At the afternoon session Miss Bartsch introduced Dr. G. E. Madison, who gave a very interesting address entitled "The Challenge of Tuberculosis." Speaking of the challenge in New Brunswick, Dr. Madison emphasized that it is a major health problem.

While the number of deaths from this disease has decreased in the past few years, Dr. Madison said: "The rate of fall is still too slow in view of the fact that the cause and means of spread have been known for many years." Stressing the need for more treatment beds, Dr. Madison said that additional beds could not be provided without nurses to care for the patients. There is an urgent need for more nurses to work at the various phases of tuberculosis treatment and control.

"The New Brunswick Department of Health," Dr. Madison continued, "has by means of the Federal Health Grants provided three general hospitals of the province with admission chest x-ray units and will equip five more hospitals in the very near future. The purpose of these units is to detect tuberculosis among those going into hospital, who may have the disease unknown to them or in early form. Apart from detecting the disease, this service will protect the hospital patients and staff."

Muriel Hunter, of Fredericton, was chairman of a discussion on *personnel policies for student nurses*. Reports from the superintendents of hospitals showed a wide variation in sick leave allowed, hours of duty, health services, and amount of time off during night duty. Miss Hunter said the discussion showed "a need for uniformity in our training schools." The following motion was carried:

"That the *Nursing Education Committee* draw up personnel policies for student nurses, such policies to serve as suggested standards to those people concerned with nursing education."

The session adjourned at 4:45 p.m. to meet as guests of the alumnae of Hotel Dieu Hospital in the Assembly Hall of the hospital for afternoon tea.

At 8:00 p.m. the Edmundston Chapter entertained the members of the association at a dinner held in the New Royal Hotel. The speaker was the Hon. J. G. Boucher, provincial secretary-treasurer.

Auxiliary Nurse Committee: Miss Hunter, as convener, stated briefly that while this committee had not been active for the past year, it was felt that, following the survey of nursing, the matter might again be taken up and some kind of legislation be secured for these workers.

Miss Bartsch introduced the guest speaker, Gertrude Hall, general secretary, Canadian Nurses' Association, whose topic was "The

International Council of Nurses' Congress." Miss Hall said there were 350,000 nurses in full membership and that nurses from Germany, Austria, and Japan had been reinstated and welcomed back after an absence of several years.

Meeting adjourned for luncheon at the Madawaska Inn, guests of the Edmundston Chapter.

Institutional Nursing Committee: The principal topic discussed was the Curriculum prepared for the schools of nursing by this committee and the following motion was passed:

"That the New Brunswick Association of Registered Nurses be approached to hold an institute for instructors some time this coming winter."

Annual meeting in 1950: An invitation to hold the next meeting there was extended by the Moncton Chapter. This invitation was accepted with thanks.

ALMA F. LAW
Executive Secretary

Increasing Vitamin C Content

Tomatoes and tomato products constitute one of the more important sources of vitamin C in Canadian diet, but canned tomatoes or canned tomato juice contain not over 50 per cent of the amount of vitamin C contained in equivalent amounts of citrus juices. According to Professor Truscott, of the Ontario Agricultural College, the objective of his department is "to breed a tomato which is otherwise suitable and at the same time contains approximately double the amount of vitamin C now obtainable, and thus equal the amounts obtained from citrus products."

"The work," stated Professor Truscott, "has proceeded far enough that it is now evident that vitamin C is inherited but its mechanism is not known. So far we have succeeded in raising the vitamin C content to the required amount, in tomato fruits which are about the size of a sweet cherry. The next job is to obtain size in the fruits without losing much of the vitamin C."

—Ontario Government Services Bulletin

Seconding motions is an easy way of feeling you are taking an important part in a meeting.

Student Nurses

What I Have Learned About Nursing

SHIRLEY SMITH

Average reading time — 5 min. 48 sec.

BEFORE STARTING my course in Queen's School of Nursing, I had some random ideas about nursing. Gradually this list has been altered. Some ideas have been removed, some modified, and many more added. Now the list is organized and could form the framework for a book. It is, however, a mere skeleton which can never come to life until flesh is provided through the ideas to be gained from my own practical experience in nursing.

One of the first things I learned about nursing was that the people connected with it were the kind of people I like. In the classroom I met first and final year students in the School; at our banquet I met the members of the School of Nursing Committee; on field trips I met many doctors and nurses; and when I had registered I met the director and lecturer in public health nursing of the School. I liked all these people so much that I feel my chances of being happy in the nursing profession are good.

I have become better acquainted with the wide choice of specialized work that a girl may follow with nursing as a background. Of these branches of nursing I learned most about public health. My first introduction to this type of work was in the field trips. These taught me that prevention is the essence of public health work. This was clearly illustrated in a trip through a modern dairy. Before I went there I recalled

the cheese factories I had seen in the country where men talked, laughed, and coughed as they worked around the open vats of milk. I was very impressed by the contrast between these old cheese factories and this new dairy. Not once was the milk exposed to the air or touched by human hands. Neither were the bottles touched after sterilization—they were transferred by a conveyor belt to the place where they were filled and capped without human assistance. Besides protecting the public, the sanitary working conditions protected the worker. This seemed a fine example of the work being done towards prevention of disease today.

In contrast to this was a tour through another establishment which, though promoting community health, was itself an example of very poor working conditions. The building was old and dirty. The atmosphere was hot and humid—a few fans circulated the air. There was no comfortable rest room or cafeteria for the workers to relax or refresh themselves when they did have a rest period—they sat on the window sills. This tour illustrated the need for more public health work.

I saw preventive medicine in action again when I visited one of the public health clinics. Here, children were being given, without charge, injections for protection against communicable diseases. The preventive work did not stop with the injection. There were booklets and pamphlets available to help the mother guide the physical and mental health of her family and herself. The work of the public health nurse was outlined to us and illustrated with a very interesting film

Miss Smith was enrolled in her pre-clinical year in the School of Nursing at Queen's University when this material was written.

and we learned, too, about the Victorian Order of Nurses. These two groups of nurses working in the community cover the schools, pre- and post-natal teaching, home care, and are constantly on the alert for any sign of illness.

In lectures I learned that all the preventive work should not be left to the public health nurses. The student nurse should do her share, not only by teaching good health habits to the patient but by being on the look-out for unusual signs and symptoms. Therefore any girl who intends to become a nurse should learn to be observant.

We were also shown how to choose a school of nursing. Before deciding on one hospital there are many questions to be asked. So many seemingly similar hospitals vary in administration and teaching methods and these should be considered carefully before making application. I had a chance to see for myself how three hospitals vary when I toured two general hospitals and one mental hospital. Naturally, the latter differed most markedly but it showed me why we were advised to choose a school of nursing which arranged an affiliation in psychiatry.

Perhaps the most valuable thing that I learned about making the choice was the importance of choosing a school away from home. At first I thought that this did not apply to me since my mother would be alone if I left her. Nevertheless I considered carefully and realized that I depended on my mother too much. I knew that I would do this until I learned to be independent by living away from home. I also realized that if my mother's sympathy was lavished on me every time I was confronted with a problem, I should feel very sorry for myself and I might never complete my training. It was pointed out to us that it is often difficult not to have favorite patients. If they were frequently my home friends and relatives it would be doubly difficult for me.

I was also taught the importance of treating each patient as a person.

Serious consequences may result if a nurse is so lazy as to refer to a patient as "bed 14" or "room 212" or "the fusion." A good nurse cultivates the habit of connecting the name with the face. A nurse should always consider the patient first. If a visitor pleads to see the patient who is too ill to be visited the nurse should not worry what the visitor will think of her when she says "No."

The final year students in teaching and supervision gave us lectures on the history of nursing from its beginning to the present day. I was impressed by the change in the social status of the nurse. In the beginning the only required quality for a nurse was strength and she was regarded as the lowest of domestic workers. At the present time the nurse must have good health, education, and character, and may, if diligent, occupy some of the best positions open to women.

In this series we heard about the Red Cross Society and Outpost Hospitals and the improvement in nursing the mentally ill. I was amazed to hear of the large number of patients who are in the latter category and glad that there was no longer the unhappy practice of chaining these unfortunate people in windowless cells. I thought of the mental hospital the class had visited with its occupational therapy department and beauty parlor.

The Canadian Nurse magazine acquainted me with some of the new techniques in nursing and revealed a portion of the lives of both the student and the graduate in various hospitals.

Everything I have learned about nursing this year can be divided into two categories—first, those things which convinced me that I would like to take nursing and, second, those things which will help me to adjust myself more readily to nursing life. When I started this year many people said to me, "Why don't you just go in training like anyone else?" I wish they would come to me now and I would tell them that this year has been more valuable to me than I ever dreamed it could be. What have

I learned about nursing this year? I have had a glimpse of hard but gratifying work, the opportunities which lie ahead of me, and the wealth of skill and understanding which I

must develop. Because of this preface I feel well prepared to open the first chapter of my nursing career, and may God write the finish—"Well done."

What I Think About Nursing

JUNE HARRINGTON

Average reading time—2 min. 6 sec.

NURSING! One of the oldest of arts and yet one of the youngest and proudest of professions. To be accepted into this profession is a great honor to any girl.

If I were asked to explain why I came to the training school, I would not know exactly how to put it. Probably, it was the idea of service to others that appealed to me because a nurse's life consists almost entirely of helping those who cannot help themselves—the sick. Great satisfaction is experienced by a faithful nurse when she sees a faint smile or hears a word of thanks from the lips of a patient to whom she has given a little comfort.

Often, we nurses in training are required to do things which provide problems. To more senior persons such things seem small and insignificant but to us they appear as mountains and the task to overcoming them is great. Much initiative and self-confidence is required. There is always the fear—"What if I do this wrong; what might the result be?" This feeling is generally followed by one of joy in the accomplishment of a task well done.

To start work on the wards is a realization of the dream of the preliminary student. However, when the eventful day arrives, the dream may be shattered as the probationer realizes her clumsiness and her ignorance. The next few times make it appear even worse and more fearful;

however, after two or three weeks of practice the feeling of awkwardness gradually disappears and it is replaced by a joy that arises from being able to do things, whether great or small, for the comfort of the sick. This creates an appreciation of the knowledge that has been acquired during the long hours spent in the classroom and the desire to study more becomes evident.

The knowledge and skills acquired through the three years equips a nurse for life regardless of what she does after graduation. If she remains single she will never have to fear being out of a job, as the demand for nurses is never fully met. There are many branches of nursing from which to choose the one she is most interested in—general duty, private duty, public health, industrial, and so on. Many chances of advancement are open to the nurse with intelligence, initiative, and sincerity.

If a nurse marries she has knowledge that will be most useful and helpful. She will never regret the days spent in the training school and on the hospital wards.

I think nursing is a wonderful profession and my greatest desire is to complete my three years of training and to accomplish what now appears to be only a distant dream.

The Peruvian Government's ratification of the World Health Organization Constitution was deposited with the Secretary General of the United Nations on November 15, 1949. Peru thus became the 67th country to join the WHO.

Miss Harrington is a student at St. Mary's Hospital, Kitchener, Ont.

Mrs. Jones had Enough

DORA DEANE

Average reading time — 6 min. 48 sec.

THERE ARE MANY KINDS of auxiliary nursing workers caring for the sick in their homes today. Some of them are well qualified for their duties. Others are as ill-equipped as the "heroine" of this true story of the nineties.

Nearly sixty years ago, a young doctor graduated from McGill and, after serving in a Chicago hospital for some time, decided to go west and set up practice. He chose as his future home a district in the foothills of the Rockies. It was ranching country surrounded by hills and deep ravines, with turbulent rivers cutting their way through. He settled in a little one-street town with its brick hotel, post office, saloon, and churches. A picturesque spot and a busy little community of ranchers and cow-boys. The doctor's office was on the top floor of a frame building. Here, for a time, he lived and worked. On cold winter evenings cow-boys would often call in for a chat and, on their way upstairs, would stumble over the cattle which had wandered in from the range seeking shelter and had "parked" themselves at the foot of the stairway for the night.

Nurses in that part of the country were few and far between. The nearest hospital, a small one at that, was 35 miles away. So it was not unusual for the "Doc," as he was called, to ride 100 miles in a day over rough roads and trails, sometimes fording a stream, to reach his patients.

Sitting in his office one afternoon, he heard footsteps approaching. He looked up to see who might be his caller. There was a tap at the door. "Come in," called the doctor, and in walked a stout middle-aged woman—a motherly-looking person with a rather florid complexion and quantities of copper-colored hair that she wore piled on top of her head. She was dressed in the style of the day—a flowing skirt, blouse with "leg of

mutton" sleeves, and a sailor hat perched on top of her copper tresses. She was carrying a parasol and reticule. The doctor recognized her as a widow who lived alone on the outskirts of the town. Her husband having died and her family being grown up, she was now left alone.

"Why, good afternoon!" said the doctor. "This is a surprise, Mrs. Jones. Don't tell me you are needing any of my pills or potions, for you always look the picture of health."

"No, indeed and I do not, doctor," replied Mrs. Jones, "but I've come for advice just the same."

"Sit down and tell me how I can help you," answered the doctor, wondering what the purpose of her visit could be.

"Well you see, Doc, its this way," his caller went on. "Here am I with loads of time on me 'ands; strong and healthy to beat the band and lonely as they make 'em. Now says I to meself, 'Emily you've raised a family and they've left the nest, and I'm that lonely with nothin' ter do. Why shouldn't I do a bit of nursin' and help out the Doc?'"

"Why, Mrs. Jones, I had no idea you were a nurse. Where did you train?"

"If you mean did I work in one of them there hospitals, then no indeed I didn't, Doc; but I raised a family, as I said before, and I guess I can do as well as another when it comes to a bit of nursin'. I thought I'd like to try me 'and with babies, helpin' them to come into the world like."

"Oh!" murmured the doctor. "You mean as a midwife, Mrs. Jones?"

His caller eased herself into a more comfortable position in the chair and mopped her face with a large handkerchief which she produced from her bag. It was a hot day, and the exertion of walking upstairs, plus talking so fast, was beginning to tell on her.

"Yes, Doc, that's it, and I thought

as how you could recommend me to some of the ladies when their time is come."

The doctor looked nonplussed and slightly embarrassed. Obviously Mrs. Jones had no idea of the qualifications necessary in a midwife. He could see that not only would he have to attend the expectant mother, but also probably Mrs. Jones, should he be rash enough to accept her offer.

"Well, my dear lady," he tactfully remarked, "much as I would like your assistance I think I should warn you that bringing a baby into the world—especially in a district such as this, with no hospital and none of the conveniences usually looked upon as necessary—is no easy matter. You would probably be called upon in the dead of night in midwinter and have to ride with me in sub-zero weather for several hours to reach your patient, who would probably be on one of the outlying ranches." And he went on to explain the various difficulties, painting as graphic a picture as he could in the hope of dampening her ardor. But not Mrs. Jones! She was as eager and persistent as ever and insisted that she could undertake the duties of midwife in a confinement "as well as another."

Without saying "aye" or "nay" the doctor finally eased her out of the office, promising to call in and talk the matter over again with her when next he passed her door. Somehow or other he never happened to be up that way, or if he were forced to pass her cottage he drove by as swiftly as possible, feeling that discretion was the better part of valor.

One bitter winter night, just as he had settled down under the blankets, there was a thunderous knock on the door. Grabbing his bathrobe he ran downstairs and, on opening the door, found one of the neighboring ranchers who had ridden in on his horse.

"Oh, Doc," the man panted, "get your things and come." "Good gracious, man! What on earth is the matter?" asked the doctor.

"It's my wife, Doc. Her time has come and things are all wrong. We

thought this time we'd manage with the nurse and not bother you, seeing you have so much on your hands. But somehow she doesn't seem to know what to do and I'm afraid unless you can help my wife she will pass out."

"What nurse?" barked the doctor.

"It's Mrs. Jones," the rancher replied. "She told us she was a midwife, but midwife my eye! She doesn't know any more about it than the newborn babe itself. Come quick, Doc, come quick."

"Now I *am* in for it," thought the doctor. Dashing upstairs he threw on his clothes, grabbed his bag and was down again in a jiffy. In two shakes he had his horses harnessed and they were off. Eighteen miles to go in zero weather! As he raced madly along over the rough road, swaying from side to side, the rancher followed on his horse. The doctor sent up a prayer that he would not be too late and wondered what problems would confront him at the end of the trail. He mentally consigned Mrs. Jones to . . . !

Presently, they reached the brow of a hill where they could see the ranch house in the distance. There was bright moonlight and the house, with its brightly lit windows, could be seen clearly. Just at that moment the door opened and a figure appeared, waving a white sheet in the air. Evidently a signal of distress! Giving the horses a touch of the whip the doctor finished the mad dash in a few minutes. Throwing the reins to the rancher, he grabbed his bag and raced into the house.

Yes, it was Mrs. Jones all right, but what a different spectacle she presented. Her copper hair was hanging in wisps around her shoulders. Perspiration was running down her face, which had lost its florid look. Her apron was crumpled and spattered with blood. In fact, she was a sorry sight. She preceded him up the stairs, gasping and panting as she went.

As they reached the landing the doctor heard the familiar wail of a newborn child. Opening the door of a room at the head of the stairs the

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"midwife" showed him in. The doctor's first thought was for the baby and there on a table it lay, alive and kicking. Upon examination he was amazed to find the cord ties in several places. Mrs. Jones was taking no chances! Having removed the unnecessary length with its many knots, he then turned to the mother on the bed. Although distressed and scared, he found nothing wrong that could not be put right. He sighed with relief

as he gently massaged her abdomen to deliver the after-birth. It had never occurred to Mrs. Jones—even though she had born her own children as she said—that this was necessary!

"The operation was successful and the patient recovered." But Mrs. Jones! When *she* recovered sufficiently to speak again she declared that midwifery was not for her. From then on she would be content as a *housewife*. She had had enough!

Nursing in Osler's Student Days

H. E. MACDERMOT, M.D., F.R.C.P. (C.)

Average reading time — 5 min. 12 sec.

Sir William Osler has left us a striking picture of the nursing conditions he found in his early Montreal days. In an address to graduating nurses in 1913 at Johns Hopkins Hospital he said:

When I entered the Montreal General Hospital, where I began the study of medicine in 1868* we had the old-time nurses. They were generally ward servants who had evolved from the kitchen or from the backstairs into the wards. Many of them were devoted women; many of them became very well-trained nurses but not all of them. Many of them were of the old type so well described by Dickens, and there are some of the senior medical men present who remember the misery that was necessary in connection with that old-fashioned type of nurse. . . .

However, there were among those women very remarkable instances of intelligence and devotion. I passed through two or three of the severe epidemics of smallpox in Montreal, and the memory of two of those nurses stands out with great clearness. . . . One, a Miss Lancashire, was in looks the old-fashioned, Dickensian nurse, but in behavior, in devotion, and in capability equal to the best that I have ever met. She nursed smallpox with a rare combination of devotion and skill and it is always a pleasure to me to look back on those days in which I was associated with her. The other was a very different type of woman: one of the sisters of a French order of nursing. She

was a highly bred woman, who had left her own country and had devoted her life to the work of charity. She had a remarkable career in Montreal, as she had charge of the large civic smallpox hospital. Though I was not formally associated with her, yet she, knowing that I was interested in special aspects of the disease, invariably sent a carriage for me when certain cases came in. Interested as I was in the study of the morbid activity of the more malignant types—the terrible black smallpox—I have seen an extraordinary number of the more virulent forms of the disease with her. She herself was often the only person I could get to assist me in the work.

Then again I saw in Montreal the beginning of the first training school. Just before I left, one of Miss Nightingale's nurses came out to take charge of the Montreal General Hospital, and it was then I saw for the first time the possibilities of a training school for nurses in a hospital.²

However, in appreciating the value of nursing training, Osler had really been long anticipated by his famous teacher, Dr. R. P. Howard. It was not for nothing that Howard had been one of those to whom Osler dedicated his Textbook. No one in Canadian medicine of the day exhibited a more penetrating mind or a deeper solicitude for professional standards.

The following extract from an introductory lecture by Dr. Howard at the opening of the 41st session of the Medical Faculty of McGill Uni-

*He really began his training in Toronto. It was in 1870 that he came to Montreal.

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versity is an instance of his advanced views. He was speaking at a time (1873) when trained nurses were unknown in Canada and training schools had only just been started in the States. Florence Nightingale's School at St. Thomas's had been begun in 1860. It was not until 1875 that Dr. Howard had the satisfaction of helping to persuade the Montreal General Hospital to bring over the nurses mentioned by Osler, under Maria Machin, to open a training school. Unfortunately, conditions were not favorable and the plan failed. Dr. Howard died in 1889, one year before his hospital at last established its famous training school under Miss Livingston.

Looming up in the future appear to me to be two things that will render the practice of medicine more successful and, therefore, more agreeable. I refer to the special education of women as nurses, and to the establishment of the department of state medicine with its special qualifications. My time will only permit of a few observations upon the former subject.

You are aware that for some time past the question of the education of women for the profession of medicine has been much discussed. Holding that the practice of medicine is not the appropriate sphere of women, I yet believe there is a very closely allied department of honorable, useful, and scientific labor, in connection with the management of the sick and the prevention of disease, for which

women, not men, are especially suited by natural endowment, viz., as educated and trained nurses. The improved training now given nurses at the useful establishments lately instituted in Germany and England does not supply the qualifications that appear to be necessary, but a more comprehensive education and training would elevate nursing to the rank of a scientific art like our own, and would secure to its members the social position and material rewards that belong and are generally given to those who combine a scientific education with a useful calling.

Such an art would, in my view, imply a liberal preliminary education at least equal to that now required of the medical student, assigning, however, a first place to natural science and a lower one to the classics. And, second, a professional education extending over three full years and embracing the following scheme of subjects: anatomy, physiology, chemistry, materia medica, pharmacy, dietetics, hygiene, and clinical instruction in nursing the sick and wounded, in dressing wounds and applying splints, etc.; such nurses to receive a nursing diploma upon examination, entitling them to practise the art of nursing and to charge fees in rates proportionate to our own.

Such a body of trained nurses would supply the greatest want we have as physicians, and would open up a career of usefulness and honorable employment to our sisters, who would then be not alone the helpmates but the "complements" of the medical profession.

REFERENCES

Dr. MacDermot, a Montreal physician, is a renowned student of medical and nursing history. He is also editor of *The Canadian Medical Association Journal*.

1. *Canada Medical & Surgical Journal*, 2: 193: 1874.

2. *Johns Hopkins Nurses Alumnae Magazine*, 12: 73: 1913.

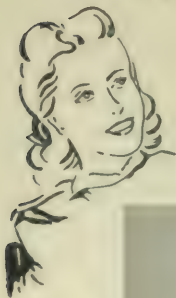
Book Reviews

Clinical Instruction, by Amy Frances Brown, R.N., B.Ed., M.S. in N. 571 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Illustrated. Price \$6.00.

Reviewed by Sister Maureen, St. Mary's Hospital, Montreal.

This book goes more deeply and more thoroughly into the methods of clinical instruction than any other work known to the reviewer. From the preparatory work necessary before a program of clinical instruction can be instituted, through to the very important step of evaluating the effectiveness of the program, the problems

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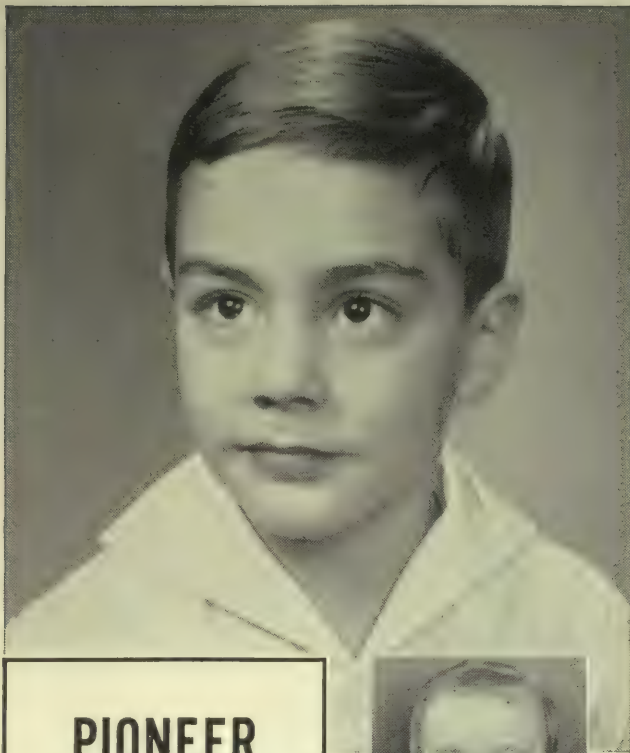


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The Canadian Nurse

VOLUME 46

NUMBER 4

APRIL, 1950

NEW PRODUCTS.....	254
WELCOME TO ALL.....	<i>Sister Columkille</i> 259
BRITISH COLUMBIA.....	<i>W. E. Ireland</i> 261
YESTERDAY WAS GRADUATION DAY!.....	<i>A. J. Macleod</i> 271
THE CASE OF THE POISONED CUP.....	<i>L. E. Ranta, M.D.</i> 275
EVALUATION OF SCHOOLS OF NURSING.....	<i>Sister D. Lefebvre</i> 278
AMBULANCE DUTY.....	<i>J. Ainsworth</i> 285
MY FEET ARE KILLING ME!.....	<i>G. Kelly</i> 287
THE NURSE AND THE RURAL COMMUNITY.....	<i>Sister S. M. Dube</i> 290
THE AGENCY'S PART IN PLANNING A STUDENT PROGRAM.....	<i>K. M. Weatherhead</i> 294
L'INFIRMIÈRE EN SERVICE INDUSTRIEL.....	<i>E. Gauvin</i> 297
NURSING PROFILES.....	299
PORTRAIT IS UNVEILED.....	300
TRENDS IN NURSING.....	303
ORIENTATION ET TENDANCES EN NURSING.....	305
WORK CONFERENCES.....	307
PROFESSIONAL ADJUSTMENTS.....	<i>C. Gillis</i> 314
BOOK REVIEWS.....	318
NEWS NOTES.....	324
OFFICIAL DIRECTORY.....	336

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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Between Ourselves

Beloved by all who know her, Sister Columkille, the gracious president of the Registered Nurses' Association of British Columbia, brings her message of greeting as our guest editor this month. Moreover, her talent as a poetess of no small merit is also displayed in this issue. Born in Torquay, England, Sister Columkille came to Canada as a young woman. She entered the congregation of the Sisters of Providence and received her professional training at St. Paul's Hospital, Vancouver, graduating in 1919. An ardent student, Sister Columkille qualified as a laboratory technician and for 18 years was assistant laboratory director at St. Paul's Hospital. She further prepared herself in hospital administration and personnel management, receiving her B.Sc. degree from Seattle College. In 1938 she was appointed to her present position of superintendent of nurses at St. Paul's.

* * *

*Every Canadian knows that **British Columbia** is our most westerly province. Those who have been in the west have been awed and impressed by the lordly procession of mountain ranges. Few are well versed in the historical lore of the province or are familiar with its industrial possibilities. That all may be well posted on these facts, we commend the interesting story presented by **Willard E. Ireland**.*

Mr. Ireland did not discuss the wide range of racial groups that compose British Columbia's cosmopolitan population. He might have noted the Doukhobors, whose unpredictable behavior at times makes newspaper headlines; the agrarian communities of the Mennonites; or the lumbering activities of the Hindu population. Actually, the largest proportion of the residents of this province are of Anglo-Saxon origin. Large numbers of its citizens have moved west from other provinces—nearly 40 per cent of the Canadian-born having thus moved in. At the time of the last census, the oriental population was several thousand in excess of the total for all the other provinces combined. One of the special post-war problems in B.C. is the astounding increase in total population, concentrated particularly in the coastal area.

Our June issue will feature a special, illustrated article on the city of Vancouver and its environs. When you go west for the convention we hope these introductions will serve to increase your sightseeing pleasure.

Though Vancouver's "liquid sunshine" is familiar to everyone, no seasoned traveller would reckon on a wardrobe containing only wet weather garments. The questions are already being asked—"What should we wear?" We recommend a suit in the event of cool weather plus light dresses if it is fine. There is little likelihood of hot weather. Moreover, no matter how warm it may be in the daytime, it is always pleasantly cool in the evenings, so you will need a light topcoat. There will be a half-mile or more to hike from the sleeping quarters to the University buildings so just in case (whisper it!) it may be raining, you will need your umbrella and toe rubbers or stout shoes.

* * *

*Most of us know a little bit about the the **Metropolitan School of Nursing**—the experimental demonstration sponsored by the Canadian Nurses' Association and the Canadian Red Cross Society at Windsor, Ont. **Agnes J. Macleod**, who is chairman of the Demonstration School Administration Committee, knows a great deal more than the rest of us. She shares some of her information with us in her description of the school's first graduation exercises. She added to her store of knowledge by personal chats with the 11 members of the graduating class immediately before the ceremony. Though their ability to make judgments on some points may be somewhat immature, their enthusiasm for nursing apparently knows no limits. You will enjoy Miss Macleod's chatty account.*

* * *

*The title of **Dr. Lawrence E. Ranta's** article suggests the "whodunit" type of literature. Since universal pasteurization is not practised in so many parts of Canada, the dangers he outlines are very real for an unfortunately large proportion of our people. With such a sure preventive measure readily available, it is amazing that any **undulant fever** is found today. A curious race of people, aren't we?*

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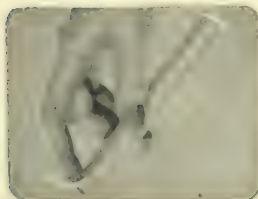
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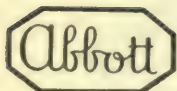
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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX

NUMBER FOUR

MONTREAL, APRIL, 1950

Welcome to All

Average reading time — 2 min. 24 sec.

NURSES OF CANADA and all nurses who are able to come to Vancouver this summer: a sincere and hearty welcome is extended to you by the nurses of British Columbia.

Why are we all meeting in Vancouver? I will answer in the thought that Dr. Esther Lucile Brown conveys to us—that "a thousand may think together." We all know that to obtain any objective there must be unity of thought and purpose. We, as members of a high and noble profession whose privilege it is to give service to mankind in health and in sickness, are especially obliged to hold the standards of our profession high. Our work can never become monotonous because we can and must embrace the whole of the patients' needs—spiritual, professional, and social. It is the noble and joyous task of the nurse to assist the first tiny breathings of the newborn, and it is also her stupendous task to assist at the last moments of those who leave the stage of this life to become permanent citizens of eternity.

Having this objective well in mind we are going to "think together" in relation to the various problems that

are met in the accomplishment of these duties. During the past year a great deal of thinking and planning has already been launched and much enthusiasm, willingness, and cooperation has resulted in the arrangement of a number of Work Conferences and interesting demonstrations in all phases of nursing. It is not my intention to dwell longer on the content of the program as it will be dealt with



SISTER COLUMKILLE

in detail in other sections of this *Journal*; but I merely mention it as an appetizer so that all may prepare their line of thought concerning their individual problems.

Mine is a very pleasant task—to welcome you to this fair province of the West. Two years ago a similar group tasted the delights of the province of the East, whose hospitality was so generously accorded. Sackville and the surrounding cities of New Brunswick made us feel so much at home both during and following the sessions; and entranced us with their many charms. British Columbia may not have the Rich Red Soil, the Magnetic Hill, and Tidal Wave, but I can assure you that the Blue Skies, the Glorious Snow-Peaked Rockies, the scenic beauty surrounding the

University of British Columbia, the many pleasant holiday nooks, and the hospitality of the citizens of British Columbia will make your journey well worthwhile. We must not forget its capital city, Victoria, where they tell me the sun shines more hours per day than in Vancouver. So a hearty welcome to British Columbia and, in conclusion, may I say—

*May we come together,
Think together,
Work together
With one chief end in view:
That all our coming, thinking, working,
May give "Service" kind and true.*

SISTER CUMKILLE, F.C.S.P.
*President
Registered Nurses' Association
of British Columbia*

Motivation

Ir is Nursing you have chosen for your life's work here on earth,
Then what motive, may I ask you, urged this choice to timely birth?
Was it just the fleeting fancy of the glory of a name,
Or the crispness of the uniform, or a passage-way to fame?

Or perhaps it was the outcome of desire to see the world,
Just to glance at numerous seaports, see the various flags unfurled?
Did you think it was the gleaming of a knowledge hard to get,
In the "Homeland" where such Science has not penetrated yet?

Or perchance you made your choosing, as we sometimes now are told,
Oh! not fame; but just for gain as a safeguard when we're old.
These motives, each and everyone, have values real and true;
But in each case, they turn to self, have only "self" in view.

'Tis likewise true that "Charity" to the "Home-fires" first belongs,
We cannot give "that they may live" if the "fire" at home is none.
So now I've put the question, rather bluntly it is true,
But I beg your kind attention, take a worthwhile point of view.

"Whate'er you do to these My least," our dear Lord said, one day,
"I'll count it just as done to Me," then—we dare not say Him nay.
So be careful in your planning that you make your motive sure,
That everything you do in life will win a heavenly score.

'Tis very wise to ponder, and to "weigh," e'er we begin,
In the balance of Eternity to guard against chagrin.
The motive should be simple, with feet planted in the sod,
Our gaze upturned to heaven, all our confidence in God.

If, when tending to His sick ones, in our daily round of care—
 We would think of His example, with Him all our duties share.
 Acting in Him, by Him, always; thinking only Him, to please;
 Serving Him in every patient, for He counts each one of these.

Not just as a case for study, or a task that must be done—
 But an act of loving kindness—His approval will be won.
 As He has often told us, in His Providence to trust;
 We shall never be mistaken, if in Him our care we thrust.

There is one thing very certain, if our life is wholly spent,
 Ever faithful to our duty, there'll be nothing to repent.
 For in time of need or trouble, if He feels 'tis for our good,
 He will be our helper, and Himself our daily food.

Then when busy days are over, and we lay our burden down,
 We shall hear the Master whisper, "Faithful one, receive thy crown."
 So you see that motivation, does to life a joy unfold,
 Changes nurses into angels, changes coppers into gold.

—SISTER COLUMKILLE

British Columbia

WILLARD E. IRELAND

Average reading time — 26 min. 48 sec.

THE YEAR 1950 is a significant one for the citizens of British Columbia for just one hundred years ago British sovereignty in the Pacific Northwest became a reality. All too frequently we think of Canada's western province as new, yet our roots run deeply into the soil of this Pacific coast. Canada had only been a British possession some nineteen years and the American Declaration of Independence was only two years old when Captain James Cook, R.N., in the spring of 1778, became the first British subject to land on Vancouver Island. He was the precursor of a great number of navigators and traders to visit these shores.

In the spring of 1792, when engaged in surveying and mapping the coast of the Pacific Northwest for Great Britain, Captain George Vancouver, R.N., wrote:

Mr. Ireland is provincial librarian and archivist of Victoria, B.C.

To describe the beauties of this region will, on some future occasion, be a very grateful task to the pen of a skilful panegyrist. The serenity of the climate, the innumerable pleasing landscapes, and the abundant fertility that unassisted nature puts forth, require only to be enriched by the industry of man with villages, mansions, cottages, and other buildings, to render it the most lovely country that can be imagined; whilst the labor of the inhabitants would be amply rewarded in the bounties which nature seems ready to bestow on cultivation.

These prophetic words, in so far as they may be applied to British Columbia, have long since become a reality.

SCENIC GRANDEUR

The natural beauties of Canada's Pacific province have made it a tourist's mecca. Three mighty mountain chains—the Rocky, Selkirk, and Coast ranges—traverse its length, providing scenic attractions beyond

description and opportunities for mountain climbing and skiing unexcelled elsewhere on the continent. To be sure in earlier times these mountains served as barriers to settlement but persistent and hardy pioneers pushed their way through and in their wake came the Canadian Pacific Railway which was completed to tide-water in 1886. This was the pioneer venture in transcontinental railroad construction in Canada. The building of the mountain division is an epic story of man's ingenuity pitted against nature's impassive obstinacy. Cuts and fills, bridges and tunnels—the Connaught tunnel under the Selkirks is five miles long—gave the victory to man and today four main lines of railroad penetrate the rocky barrier.

Paralleling and intersecting the mountain ranges are myriads of lakes and mighty rivers, adding variety to the scenic beauty and allurements to the inveterate angler. These were the original transportation routes. The Peace, Columbia, Fraser, Skeena, and Stikine rivers, some of them turbulent and dangerous, provided the natural lines of communication used by the explorers, the fur-traders, and the pioneer settlers. The Pacific seaboard of the province is dotted with innumerable islands of all sizes and

hundreds of fiord-like inlets create a coastline estimated at over 8,000 miles. Towering rocky cliffs rising five to eight thousand feet from the water's edge, hundreds of cataracts and waterfalls feathering the rocky slopes, further to the north impressive glaciers debouching into the sea itself, all set against a background of mighty evergreen forests, combine to provide pleasures without end for the itinerant visitor.

Once when the construction of the Canadian Pacific Railway was under discussion a great Canadian statesman made deprecatory reference to British Columbia as a "sea of mountains." This, it was then felt, was the major handicap to the future progress of the region but, in reality, therein lay the secret of its ultimate importance to the Dominion of Canada. Buried within these mountains were huge mineral deposits, the variety and value of which is only now beginning to be realized. Moreover, mountains of necessity mean also valleys and in these valleys agriculture has flourished. As a result British Columbia has become an important producing province of the Dominion, being surpassed only by Ontario in per capita production values. In addition to its generous natural endowments British Columbia is also possessed of variations in climate which have contributed greatly to the variety of its economic life.

To illustrate the importance of these river-valleys perhaps it would suffice to describe two typical regions, both of which have in the past played an important part in the historical development of the province and which today contribute so greatly to its importance.

OKANAGAN VALLEY

Of the many valleys perhaps none is so widely-known as the Okanagan Valley which lies in the southern interior of the province close to the border of the United States. Mountain ranges flank either side of a crystal clear lake which extends some 80 miles from north to south. The lake is drained by the Okanagan River



Revelstoke and Mt. Begbie, B.C.



All photos courtesy of B.C. Govt. Travel Bureau

Williams Lake, B.C.

which empties, in turn, into the mighty Columbia River in American territory. In the early days before there was permanent settlement along the coast this valley had become an important commercial highway. The fur trade was the magnet which drew white men over the Rocky Mountains. At first their interest lay farther to the north in the area opened up by the Peace River and its tributaries and farther to the south in the basin of the Columbia River. Trading posts were established in both areas and eventually the Okanagan Valley became an important link between the two regions. For years vast quantities of supplies and furs passed over the "old brigade" trail.

As settlers began to push into the country from the more thickly populated East the fur trade dwindled and disappeared and for the time being the Okanagan Valley became a cattle country. The rainfall was so slight that ordinary agriculture was impossible but on the mountain slopes grass grew in abundance and for a time the cowboy reigned supreme. To

refer to mountain "slopes" hardly gives the correct impression, for actually along both sides of the lake and at different levels of elevation are stretches of flat land called "benches." The scene is now completely changed for irrigation has been introduced and today the "benches" are covered with orchards. Far back in the mountains dams have been built and from these the water is carried to the lower levels in immense flumes from which it is distributed to the individual orchards by means of a series of ditches.

Spring in the valley is a glorious sight—thousands of fruit trees in full blossom are banked on either side of the lake for miles and miles. In the late summer and early autumn the scene is equally fascinating for the air will be heavy with the perfume of ripened fruit. Soon thousands of boxes of apples, most famous of which is the MacIntosh Red, will be on their way by steamer and train to the markets of the world. Other fruits are grown in abundance as well—cherries, apricots, and peaches—and canta-

loupes and tomatoes are coming to be grown in large quantities.

FRASER VALLEY

Much nearer to the coast is the equally important Fraser Valley. The Fraser River, nearly 750 miles in length, is the largest of the many rivers of the province and derives its name from the intrepid explorer, Simon Fraser, who descended the river to its mouth in 1808. This river takes its rise high in the Rocky Mountains and at first flows in a northerly direction before making a sharp bend near the city of Prince George to begin its headlong rush southward to the sea. In the interior it passes through and drains a large plateau area, part of which, particularly the Chilcotin country to the west, is an important cattle country. At Lytton it is joined by the Thompson River from the east and shortly thereafter the river plunges into a narrow gorge to break through the Coast Range which bars it from the sea. Cataracts, whirlpools, and rapids, with the sheer perpendicular walls of the canyon rising in many places several thousand feet, combine to make an awe-inspiring sight to which any traveller can bear witness, for both transcontinental railways use this route to the coast.



Mt. Arrowsmith, Vancouver Island

In comparatively recent years automobile traffic through the canyon has been possible with the construction of the scenic Cariboo Highway. A trip over this motor highway cannot fail to thrill the visitor, the more so when it is recalled that this road, with its many difficult engineering problems, was preceded by the original Cariboo Road. The necessity of providing means of access to the rich gold fields of the Cariboo district, centring about Barkerville, impelled the construction of the original road in the early 1860's in the face of almost overwhelming difficulties. Today the sound of the motor horn has replaced the crack of the bull-whip. While no longer does one see the creaking old stage-coach, wearily climbing the long grades and warily edging its way along what was little more than a ledge carved out of the precipitous canyon walls, nevertheless one cannot but feel humble at the memory of this monument to the pioneering spirit.

Freed of its narrow rocky confines as it rushes through Hell's Gate, the Fraser River begins a more leisurely course through a gradually widening valley. For thousands of years this madly rushing river has been carrying down the fine silt washed from its banks in the upper country and, in consequence, in its slower reaches near its mouth there has been built up a large and typically fan-shaped delta some 30 miles wide at its sea-front. Point Roberts forms the seaward extremity of the southern boundary of this delta while to the north is the city of Vancouver, which lies between the north bank of the Fraser River and Burrard Inlet. The river still continues annually to deposit large quantities of sediment, thus necessitating the constant dredging of the ship-channel which leads up-river to New Westminster, British Columbia's thriving fresh-water port. It is one of the curiosities of history that although Britain's leading navigator in the Pacific Northwest, Captain George Vancouver, after whom Canada's leading Pacific port is named, noticed the discoloration of the Gulf of Georgia, caused by the muddy



"The Jaws of Death" South Thompson River

water from the Fraser River, he failed to discover its existence although he passed within a few miles of its mouth.

AGRICULTURE

The rich soil of the Fraser River delta is now under intensive cultivation. Both here and in the immediately adjacent valley immense crops of hay and grain are raised and an extensive dairy industry has grown up which finds a ready market in the metropolitan area of Vancouver. In addition hundreds of small "truck-farms," producing vegetables for the urban area, are scattered over the delta, most of which are operated by the industrious Chinese who have settled in the province. Farther up the valley small fruits of every kind—strawberries, raspberries, loganberries—are grown in large quantities.

Agriculture, which is British Columbia's third ranking industry, is not confined only to these two river valleys. It flourishes in all sections of the province. Parts of Vancouver Island are admirably suited to small fruit farming, for good soil is here

combined with an excellent climate. Thanks to the tempering effect of the Japanese current the whole of the coastal area enjoys a salubrious climate which, with the assurance of ample rainfall, makes for successful farming. Much farther to the north the grain-growing potentialities of the Peace River Block and of the Bulkley Valley are only now beginning to be appreciated. The total value of the agricultural products of the province amounts to nearly \$120,000,000, of which dairy products, fruits, fodders, poultry products, and live-stock contribute over 60 per cent.

MINING

Had British Columbia been solely dependent upon agriculture her progress would, in all probability, have been very slow. The first forward step in her path of progress came as a result of the gold discovered on the Fraser River, the resulting gold rush in 1858, and the successful development of the Cariboo gold-fields in the 1860's. Since that time mining, in general, and gold-mining, in parti-

cular, has been one of the leading industries of the province. It is a far cry from the pan and wooden cradle and "long Tom" methods of the argonauts of '58 to the huge hydraulic operations of today. In addition, placer mining has to a large extent been superseded by quartz or lode mining. The Bralorne, Premier, and Pioneer properties on the mainland and Zeballos on Vancouver Island are centres of gold-mining operations which produce about one-twelfth of the total Canadian gold output.

The untiring efforts and unconquerable optimism of the prospector soon unearthed the vast mineral wealth locked in the mountains of British Columbia. In extent and variety the mineral resources of the province are such as to defy summary description. The turning-point came in the late 1890's with the great boom in base metals. The centre of provincial activity was the Boundary country in the southern interior, with Greenwood, Phoenix, and Rossland as typical boom towns. Vast quantities of lead, zinc, and especially copper were mined. While in due course the boom collapsed, nevertheless the basis for a mining industry has been well laid. Some years later the discovery of a method whereby the complex ores from the Sullivan mine at Kimberley—one of the largest hard-rock

mines in the world—could be treated led to the development of the enormous property of the Consolidated Mining and Smelting Company at Trail. Today British Columbia ranks first among the other Canadian provinces in the production of silver, lead, and zinc, as well as the rarer metals of the cadmium group. Large copper properties are in active operation, notably the Britannia Company on Howe Sound, near Vancouver. Coal is also mined in such widely separated districts as Nanaimo on Vancouver Island and Fernie in the heart of the Kootenay country in the Rocky Mountains. With an annual production in excess of \$113,000,000, mining has advanced to second rank among the industries of the province.

FISHERIES

To many people the name British Columbia is immediately associated with the salmon. With such an immense length of coastline it was only reasonable to suppose that the fishing industry would be highly developed in the province. In a sense this is the pioneer industry for, in the years before the coming of the white man, salmon was a staple food of the Indians and they were fully aware of the phenomenon now known as the "run." The young salmon is hatched in interior waters but soon finds its way to the sea where for three years it disappears. Then suddenly it reappears on the coast seeking to return to the very spot where it had hatched. Unlike the Atlantic species, the Pacific salmon never returns to the sea again, as it dies either on its way to the spawning grounds or shortly after it has reached them. This instinctive urge, which forces the salmon to battle its way against the current of the swift-flowing British Columbia rivers, produces the "salmon run." During this season fishermen are busy at the entrance of all the rivers leading to the interior and canneries have been built in close proximity. The Fraser, Skeena, and Nass rivers are particularly important centres. Unfortunately, of late years there has been a marked decline in the "run," in all



Skeena River near Skeena Siding, B.C.

probability due to the policy of unrestricted fishing. In consequence, in an effort to conserve the supply, the government has established hatcheries and built fish-ladders to assist the salmon over obstacles in the rivers which retard its return to the spawning grounds.

The salmon alone accounts for about two-thirds of the total value of the provincial fisheries. Gradually the halibut fishery is coming to be of greater importance. This industry is centred about Prince Rupert and involves an entirely different technique from that used in the salmon industry for the halibut is found miles off-shore on the "banks." This industry has also increased the herring fishery, as herring are the bait used in catching halibut. Salt herring normally finds a ready market in the Orient. In bygone days the departure and return of the sealing fleet were great events but this industry has almost entirely disappeared. On a very limited scale, however, the equally intriguing whale fishery is still carried on from bases on the Queen Charlotte Islands.

LUMBERING

One of the crowning beauties of British Columbia is its evergreen forests. Towering Douglas firs, cedars, and spruce cloak the hills and mountains of the coastal area from sea-level to snow-line. Of them all the Douglas fir is the most majestic, for it often reaches a height of 150 feet with a girth exceeding 30 feet. Economically, the forests are our greatest asset for annually they produce values well in excess of \$100,000,000. From both the esthetic and economic points of view it is unfortunate that improvident logging methods and ravaging forest fires annually destroy thousands of acres of timber, but it is to be hoped that in the future greater efforts will be made to assure the continued existence of this double asset. The close proximity of the better stands of timber to water has made the problem of transportation of the logs to the saw-mills an easy one for solution in British Columbia. While in some localities

log-trains are used, the more common sight, even in the interior, is the huge boom of logs being towed by a tug to the saw-mill. Vancouver, New Westminster, and Port Alberni are the centres of this industry and from these ports sawn lumber and shingles move quietly over the oceans to the four corners of the earth.

PAPER MAKING

Of increasing value in recent years is the allied pulp and paper industry. In this respect British Columbia is most fortunately situated. An abundant rainfall in the coastal area makes it possible for its many rivers to afford excellent all-year-round sites for hydro-electric developments in close proximity to the forests. Cheap power, a prime requisite for the successful conduct of this industry, is consequently readily available. Large and valuable pulp and paper mills are to be found at Ocean Falls, Powell River, and Port Alberni.

BOUNDARIES PROBLEMS

From the foregoing account it would only seem just that British Columbia, without undue presumption, might claim for itself a rather meteoric rise to prominence. Admittedly its tremendous extent—366,255 square miles—and abundant natural resources contributed in no small degree to its progress. But the province has never had a large population; even today it only numbers slightly more than 1,000,000—a figure far exceeded by many cities. Consequently its accomplishment has been the result of the diligent labor of an enthusiastic population who are as resolutely confident of the future of their province as they are proud of its past history. Yet it must never be forgotten that British Columbia is a young country, for it is just one hundred years since the first serious attempt was made to settle the region now comprised within its boundaries.

Attention first came to be centred on this part of the Northwest Pacific because of a small marine mammal—the sea otter—whose pelt found ready

sale in China. A Russian explorer, Vitus Behring, made the initial discovery but it did not become general knowledge until after the visit of Captain James Cook in 1778. The Spaniards had been gradually pushing their explorations northward from Mexico and four years previous to Captain Cook's arrival had actually sailed in the waters off this coast. But to the British navigator goes the honor of having made the first landing on these shores and also the credit for having made the first chart of the coastline. The possibility of enormous profit from the sale of the sea otter pelts drew traders of all nationalities to the Pacific Northwest. The first, Captain James Hanna, an Englishman, after a sojourn of but a few weeks on the coast, sold his cargo in Canton for \$20,000. Soon Spanish, Russian, and American traders were also actively engaged in the trade and inevitably commercial rivalry gave place to international animosity. The most serious rivalry existed between Great Britain and Spain and almost precipitated a war. Ultimately the Nootka Sound Convention was drawn up which, to all intents and purposes, left the whole region open to traders of any country. Captain George Vancouver was sent out to carry through the provisions of this agreement and, in addition, he was to explore and chart the coast, for at that time the fabulous Northwest Passage between the Atlantic and Pacific oceans was still being sought. Captain Vancouver spent three years at work on this coast, producing maps and charts that are amazingly accurate even today.

All the activity in the maritime fur trade centred around Nootka Sound, an inlet on the west coast of Vancouver Island. With the sudden collapse of the Chinese market the whole trade disappeared and Nootka sank into insignificance, in fact nothing permanent remains as a relic of an important and romantic period in the history of the province. But just at this stage the possibility of an overland fur trade was being carried into effect. The North West Company, a

Canadian fur trade concern, was seeking to penetrate into the country west of the Rocky Mountains and gave every encouragement to exploration of the unknown region. In 1793, one of their employees, Alexander Mackenzie, became the first white man to come overland from Canada to the North Pacific. His was an epic voyage—accompanied by a small party of voyageurs he followed the Peace River pass through the Rocky Mountains and eventually reached the upper stretches of the Fraser River. As this stream led southward and as his objective lay westward, Mackenzie soon branched off. After following an old Indian trail and enduring untold hardships he reached tide-water at the mouth of the Bella Coola River which empties into Bentinck Arm. Simon Fraser's equally hazardous journey was also sponsored by the North West Company in their quest for knowledge of the country.

Soon trading-posts were established—at first in the area adjacent to the Peace River pass, but soon further afield, even as far south as the Columbia River. In 1821 the North West united with the Hudson's Bay Company and thereafter British interests in the territory west of the mountains was left almost wholly in their hands. They made every effort to maintain control of the region and were at first completely successful. Naturally their prime interest was the conduct of the fur trade and, in consequence, colonization of the country was ignored. At this time neither the United States nor Great Britain possessed the title to the country west of the Rocky Mountains for, by agreement, it had been left open to the citizens of both countries. In the 1840's a steady stream of American settlers began to pour over the mountains into the Columbia Valley. The settlement of the boundary question thus became a necessity but it was a difficult task to reach a satisfactory solution. The British laid claim to all the territory as far south as the Columbia River while the United States laid a counter-claim as far north as 54° 40'. Public opinion in both countries became



Breaker Beach near Bamfield, Vancouver Island

aroused. In the United States the cry "Fifty-four forty or fight" became part of an election campaign in 1844. Once again the possibility of war was imminent but good sense prevailed and the Oregon Treaty of 1846 adopted a compromise boundary along the 49th parallel, thus setting the southern limit of British Columbia.

ESTABLISHING GOVERNMENT

This advance of the American frontier aroused the British government to action. In order to forestall any further intrusion it was decided to establish a British colony on Vancouver Island and, in 1849, this plan became a reality under the auspices of the Hudson's Bay Company as sole proprietor of the colony. Provision was made for a royal governor and the first appointee was Richard Blanshard, who arrived at Fort Victoria on March 11, 1850. He did not long remain in the colony for the real power was in the hands of the Chief Factor of the fur trade company—James Douglas. In 1852 Douglas became governor and by his years of service has earned for himself the title "Father of British Columbia." That same year, because of gold dis-

coveries on the Queen Charlotte Islands, that archipelago was added to the original limits of the colony. Unfortunately, the colony of Vancouver Island did not prosper. For one thing the gold-fields of California were much more attractive to the would-be colonist and, in addition, the Hudson's Bay Company was not an ideal colonizing agency. By 1855 scarcely 750 whites resided on the island, yet despite its small population it possessed the full government of a typical crown colony. In fact the first legislative assembly ever to be convened west of Toronto in British territory met in Victoria in 1856 and was composed of seven members.

During all this time the mainland still remained a fur preserve of the Hudson's Bay Company. But, as in the case of the Queen Charlotte Islands, gold discoveries became the *open sesame*. In 1858, when news of the rich finds reached California, there ensued a regular stampede to the Fraser River. Thousands of expectant miners poured into the country within a few months and in response to this totally unexpected situation there was called into being the separate mainland colony of British Columbia



Slocan Lake, B.C.

with James Douglas as governor. As the miners pushed ever further inland from the bars of the lower Fraser other valuable mining fields were opened up, notably the Cariboo district where Barkerville came temporarily to be one of the largest towns on the continent west of Chicago. Each advance of the miner increased the problems and the expense of government in this huge area. Roads had to be built and the terrain was particularly difficult. Mention has already been made of the construction of the famous Cariboo Road under the supervision of the Royal Engineers sent from England. In 1862 gold was discovered still further to the north on the Stikine River and once again a separate colonial administration was established with the creation of Stikine Territory, with Douglas as administrator.

But like most gold rushes the boom days soon passed away and a period of depression set in. The population dwindled, business was stagnant, taxation unduly heavy, and discontent began to grow. Even Victoria,

which had become a thriving commercial centre as a consequence of the gold rush, shared in the decline along with the mainland colony. In a vain effort to economize in 1866 the various colonial administrations were united under the name of British Columbia. For a time New Westminster became the capital of the united colony but it was soon removed to Victoria where it has remained ever since.

This union, however, did not bring the anticipated relief and once again British Columbia sought a remedy. In 1867 two events occurred which suggested possible ways out of the difficulty. That year the United States purchased Alaska from the Russian government and, with British territory thus sandwiched between American possessions, some came to look upon annexation to the United States as the solution of British Columbia's problems. That same year the Canadian confederation had been launched and many British Columbians eagerly anticipated the inclusion of their colony in the new confederation. Annexation to the United States was from the beginning a lost

cause. The colony of British Columbia became a province of the Dominion of Canada on July 20, 1871.

One of the terms of union called for the construction of a transcontinental railroad, for without such a link the union was doomed to be more apparent than real. After long delay in 1886 the Canadian Pacific Railway was completed to tide-water on Burrard Inlet and British Columbia became in fact a part of the Dominion.

Since that event her progress has been rapid and extensive. No better evidence of this fact is to be found than in the history of the city of Vancouver. In 1886 there were only a few struggling settlers in what has since become the great Pacific port.

Such, in broad outline, is the story of the evolution and achievement of British Columbia—bulwark to Canada's industrial system and gateway to the trade routes of the world.

Yesterday was Graduation Day!

AGNES J. MACLEOD

Average reading time — 12 min.

AS MOST OF YOU were not able to be present at the graduation exercises of the Metropolitan School of Nursing, I am sure you would like to hear something of it. I arranged to arrive in Windsor on an early morning train, went directly to the school, had breakfast with Miss Fidler. During the morning I had an opportunity to spend some time around the library table, informally chatting with the eleven members of our first graduating class. I was anxious to find out what their plans were, and how they felt about their 25 months' training experience, as well as how they viewed nursing in 1950 from their vantage point as students about to become graduate nurses from this much-discussed demonstration school.

The school, as you know, opened on January 19, 1948, and yesterday, graduation day, was February 18, 1950—exactly 25 months! The first class started out with 13 students and the following 11 students graduated:

Elinor Marguerite Anderson, Indian Head, Sask., Barbara Elizabeth Austin, Sudbury, Ont., Violet Mary Burchell,

Fredericton, N.B., Jean Grant Dunbar, Vancouver, B.C., Jean Margaret Elford, Cottam, Ont., Georgina Folean, Windsor, Ont., Mary Elizabeth Hyatt, Wheatley, Ont., Mary Lorraine Keeler, Calgary, Alta., Shirley Joan Peart, St. Catharines, Ont., Huguette Paule Quenneville, Sturgeon Falls, Ont., Frances Elizabeth Waterous, Brantford, Ont.

It will be noted that this group comes from five provinces, although the greatest number is from Ontario. It is interesting to note that seven out of the eleven are remaining in Windsor to work as general duty nurses at the Metropolitan Hospital, one returns to British Columbia, one to Alberta, one to Saskatchewan, and one to New Brunswick. All four of these nurses have already made plans to work in hospitals in their respective provinces.

One of the objectives of the Metropolitan School has been to prepare nurses for first level graduate nurse work in hospitals. The emphasis throughout the whole course has been on *nursing the patient as a person* and giving total nursing care. The whole educational pattern has been one of integration—building all the component parts into the proper care of the patient. When I asked the students what they felt might be wrong with nursing today, this emphasis

Miss Macleod is chairman of the Demonstration School Administration Committee, a sub-committee of the C.N.A. Educational Policy Committee.

showed in their replies. They felt that too many nurses seemed more interested in treatments than in their patients as individuals; that too many nurses are not sufficiently interested in their own profession or in its problems; that nurses generally seem more interested in going into specialized fields, instead of giving good bedside care. One nurse said, "Could the fault be in nursing education? The teaching responsibility of every nurse should be stressed more. Too much emphasis is put on income and hours of work. More interest needs to be taken in the profession itself, in nursing associations and the whole nursing situation."

Whether the emphases in the course or the high calibre of instruction is the answer, certainly these students could never be accused of lack of interest in professional matters. I would say they love nursing. Let us hope they always will. They have already passed their R.N. examinations, made application for immediate registration, and I am quite sure that no one of them will fail to also seek membership in their provincial nurses' association in Ontario, as they all know what the Canadian Nurses' Association stands for, and that in Ontario it is necessary for registered nurses to also join the R.N.A.O. before they are members in good standing in the C.N.A. Those who go to other provinces will be accepted by reciprocity for registration in the provinces where they take up residence.

Each student had one month vacation each summer and two weeks at Christmas. They averaged two weeks of night duty, (one on the evening and one on the night shift), plus additional nights during their obstetrical experience.

Though the Metropolitan Hospital in Windsor was used as the main training field, with experience in its various departments, each student also spent three months at the Ontario Hospital, London (psychiatry), one month at the Hospital for Sick Children, Toronto, to supplement their pediatric study, and one month at the Essex County Sanatorium.

I asked the students how they felt about their own training, following the opportunities they had had of working with students from other schools of nursing in affiliation programs. They all stated that theirs was certainly as good as other courses and definitely better in some respects. They mentioned particularly their own health instruction and that they also received more detail in all the instructional courses than other students—or so they thought.

Actually, Miss Fidler has had excellent reports of her students' clinical work from the head nurses and superintendents of the hospitals where our students affiliated. It would seem from this angle of bedside nursing in clinical fields that the shorter course students have done extremely well. Right here I should remind you that the students at the Metropolitan School spend a good deal of time actually giving total nursing care to patients. Too often our public seems to think that, because our school is "independent" of the hospital in the financial and administration sense, the students are not actually trained in the wards. Every nurse should explain this point to her acquaintances. The hospital ward is essential for their basic nursing training, but the difference here is that the hospital has no control over the students' time—that must be carefully adjusted by their own instructors and supervisors in relation to their actual experience requirements.

The students themselves believe that they received adequate experience in all branches of nursing. The very fact that their time has been so carefully regulated has meant that they have had time for study, rest, and recreation, and are happier and healthier than the average students in the usual hospital school of nursing where students' experience on the wards is subject to the nursing service requirements of the hospital. All the students believe that their orientation into each new nursing situation has been particularly good.

Then I asked them as to the pros and cons of living in a residence. Their

answers were unanimous—that student nurses *should* live in a residence. Actually, one of these students had been allowed to live at home from the beginning of the school. However, when the new residence was ready she asked permission to move in, as she felt she was missing too much of the fun. They considered it an excellent way to learn how to get along with people. One nurse said she thought the regular hours, discipline, and gradual building up of group morale were necessary for nurses in training.

Because these first four years of the Metropolitan School are experimental, and the financing of the school assured, a token tuition fee of \$50 a year was charged all students. When asked what they thought a student should pay for such a course, the majority thought it should be \$100 a year. They all thought the 25-month course had been long enough for a good grounding in basic nursing and they all said they would advise any of their friends to apply to the Metropolitan School. It would appear that they may have already done so because Miss Fidler reported at the graduating exercises that there were over 200 inquiries already for the fall class and 20 completed applications to date. Maybe we shall need another such school soon!

I asked them what plans they were making for further study. Some have no plans past their immediate intention to do hospital work. One student, a former R.C.A.M.C. physiotherapist with over two and a half years' service experience in Canada and overseas, has already chosen pediatrics as the field she plans to stay in. She is taking further experience in Toronto and then returning to New Brunswick to work in a pediatrics department of a general hospital. One student is planning to work in the obstetrical division at the Metropolitan Hospital, Windsor, and two are hoping that, after several months in general hospital nursing, they will be able to go to university to study public health. One of these nurses is particularly interested in eventually working with the Victorian Order of Nurses.

Perhaps you will say, "Imagine worrying the poor students on their graduation day with such questions!" Actually they were so nice about it, I don't believe they minded too much and if they did I hope they will forgive me, and remember it is all in a good cause. But just there, do you realize how different it is to a regular school of nursing where on graduation day students are on duty until the very last minute and dash off in time to get ready for graduation? Of course, most graduations for that reason take place in the evening, in order to let as many of the school attend as possible. Not so at Windsor! The graduating class left me to join friends and relatives for lunch, and fond mothers and fathers as well as brothers, sisters, and grandparents and even aunts had converged on Windsor for this happy day.

The graduation exercises were held in the school building which had lovely bouquets of flowers every place. Soon after two o'clock people commenced to arrive. The whole ceremony was a nice homey affair, held in the two large adjoining classrooms. By three o'clock the rooms were filled, leaving space on the platform and at the front for the students of the whole school which now numbers 58. Their first students had had a part in building the traditions for the school. They helped plan the grey, short-sleeved one-piece uniform with white shoes and stockings. They do not wear bibs or aprons. The first grey uniforms have faded, so that the senior class appeared to be in almost white uniforms, and the most recently arrived students are in really grey uniforms. They looked crisp and efficient. The graduating class had black bands on their caps but there is no other distinction between the classes. The graduating class also had the fun of designing their own school pin—a plain gold pin with M.S.N. on it, about the size of a 25 cent piece. Although the uniforms have shoulder epaulettes on them, so far they have not been used to show seniority.

I am not going to tell you anything about the actual program, other than

to say it was a very pleasant occasion. Everyone was conscious of the fact that this was something a little different as graduations go, and that it was the culmination of two years of hard work, especially on the part of the team built up there—between the C.N.A. representatives, the city of Windsor, and the Board of Governors of the Metropolitan School of Nursing. We of the Canadian Nurses' Association are very grateful to the Canadian Red Cross Society for making this undertaking possible. When I heard Miss Fidler give her report and listened to Miss Kathleen Russell give her talk to the graduating class, I again realized how fortunate we are in our national professional organization to have women such as these who, by the very strength of their conviction, make dreams become a reality. For such is this Metropolitan School! The whole program, made possible through the vision of Miss Russell, who presented such a concrete plan that the Canadian Red Cross Society was convinced of its value, was brought to this first graduation day through planning, talking, selling, and directing, which I am convinced only a Nettie D. Fidler could have had the perseverance to have so well achieved. One of our neighbors from across the border, who, I know, has watched this demonstration with considerable doubt in her mind, said she felt most of the success of our school thus far was undoubtedly due to the calibre of the teaching faculty at the Metropolitan School. So to Miss Fidler, Miss Martin, and Miss McPhedran, who have carried most of the teaching and administrative load, as well as to the more recent members who have joined the school's staff, we owe a great deal.

Miss Fidler in her report paid par-

ticular tribute to all those people in Windsor who have been well-wishers of the school since its inception and to whom we owe our thanks. After all, a hospital is the local health centre of the community and the aim of the Metropolitan School is to demonstrate how, in a controlled educational situation through co-operation with hospitals, student nurses can be efficiently trained in a shorter time than has been previously thought possible. If the Metropolitan Hospital in Windsor can thus be provided with more and better trained hospital nursing service, and so meet its health service needs, it is not likely that the community of Windsor will willingly see the Metropolitan School fail to carry on in the future when so much local and community interest and goodwill is evidenced after just two years of our four-year demonstration period have elapsed.

During the tea hour the place buzzed with laughter and chatter. Gradually the good-byes took place. Most of the new graduates were going home for a bit of a holiday before starting on their professional careers. Everyone felt it had been a very successful first graduation. We didn't have an opportunity to bid everyone good-bye but, as I assured the group in the morning, we of the C.N.A. will always want to know how they are and where they are. I am sure I was expressing every C.N.A. member's sincere wish when I said we hoped they would prosper in whatever type of nursing they undertook, and that they would find joy in carrying on their professional life.

I hope I have managed to give you something of the feeling of those of us who were fortunate enough to be present.

The **Cumulative Index** for 1940-44 went into the mail early in March. Unfortunately, labels came off four envelopes and the copies were returned. Would the four who ordered but did not receive their copies please write us.

The 1945-49 Index is nearing completion and should be in the mail within a month.

The Case of the Poisoned Cup

LAWRENCE E. RANTA, M.D., D.P.H.

Average reading time — 10 min.

UPON A COUCH lay the near-dead body of a man, an empty chalice in his hand. Around him stood his sad-eyed friends and family. His face alone was filled with contentment. In a quiet voice he said to a friend: "Krito, we owe a cock to Aesculapius. Discharge the debt and by no means omit it." And with that he died.

My purpose in recalling a picture of Socrates' death is to contrast his attitude with that of another man who also chose his own fate. Moreover, while Socrates was careful to remind his friend to pay a sacrificial debt to the god of healing arts for the sacrilege of taking his own life with a poisoned cup, the other man was inclined to object to the sacrifice for sacrilege.

Bruce Malox (this name will hide his true identity) was a clever man but, as events will prove, not a wise one. He and his small family spent a summer vacation at the beach. When the vacation was over, Bruce reluctantly took his family back to the city. Within the week he was at his work, brimful of energy, so much so that, for the first time in his life, he began to have restless nights. By Christmas he felt vaguely ill. The following summer vacation he spent in the hospital, where he suffered regret for having wilfully defied his better judgment and drunk from a poisoned cup.

Mary, his wife, had been the first to notice a change in him. Bruce became most irritable during the fall. Some times he was worse than at others. After his short temper had flared up into a family quarrel, he would become depressed and spend a day in

bed complaining of an overpowering tiredness and pain in his back and knees. On one of these occasions Mary called in Dr. Brown, her baby's doctor, who said that Bruce was working too hard and was too much "on edge." He gave Bruce a tonic. It seemed to do some good.

After a week in bed he felt able to cope with the office. But the pre-Christmas rush of business was often too strenuous for him. Quite suddenly he admitted to himself that he was not well—his staff had long been convinced of this—and he allowed this realization to spur him into an appointment with a physician.

He was rather dissatisfied with his visits, because Dr. Wilson seemed so vague about naming the cause of his illness. There was talk of arthritis, of other chronic diseases. He was x-rayed, and wired to various machines. He even heard an ugly whisper: "Psychosomatic case, you know, family trouble." He drank many-colored medicines. He ate many-sized pills. At times he felt better, at others he owned all the world's ills.

As winter budded into spring, he finally asked his doctor to send him to a specialist. Dr. Ross was suggested and again the prodding and testing began. The prodding showed nothing to account for the disorder. But this very fact led Dr. Ross to suspect the nature of the disease and he became interested in the results of three tests: a skin test, a serum-agglutination test, and a phagocytic test. He knew that none of these could be relied upon to prove his suspicions, but their results would assist him in the proper reading of his patient's symptoms. In other words, the diagnosis was to be largely a clinical matter.

Dr. Ross had noted that cases of this nature often had such a wide

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range of symptoms that the disease could masquerade under many guises, making diagnosis most difficult. The majority of cases had a chronic history, extending over one or more years, during which time the patient suffered frequent relapses into febrile ill-health, although some, like Malox, were entirely afebrile.

In common with experience everywhere else, he was seeing an increasing number of cases every year. It was hard to say whether the increase was real or apparent. Either the disease was spreading or, despite the difficulties, it was being diagnosed more often. He feared that it might be too much of the former and too little of the latter.

When the results of the tests carried out by Dr. Ross were recorded, the intradermal test was markedly positive. Having comparable significance to the tuberculin test in tuberculosis, this test was ordinarily positive in about 90 per cent of proven cases. On the other hand, the serum-agglutination and the opsonocytaphagic tests were both negative, agreeing with the usual findings with these tests, since they were each positive in only about 25 per cent of cases.

Taken into account with the history of Bruce's illness, the positive skin test was thought to have diagnostic value. Efforts were made to isolate the causative agent from the blood during one of his periods of greater illness, but the usual outcome in chronic cases was reported—the cultures were all negative.

Thus arriving at the diagnosis, Dr. Ross was now faced with the problem of treatment for a disease having no sure cure. Many systems of therapy were available, all receiving strong support in some localities, while elsewhere they were equally strongly condemned.

In general, antiserum, sulfonamides, penicillin, and streptomycin had won few supporters. Vaccines and bacterial extracts had been used with some value claimed. In acute infections (those occasional cases that burst sharply after infection and run a strong, short course), aureomycin had

won considerable success but its usefulness in chronic cases was not established.

In the course of the examination of his patient, Dr. Ross probed carefully into his past activities. Gradually he pieced together an account of a wonderful family vacation at the beach. But some details of it had ominous import.

Every morning, after he returned from fishing, Bruce used to fetch the milk needed by his infant son from a near-by farm. He would take along a large pitcher and bring it back, brimming with a grade of milk rarely seen in his home in the city. Mary boiled the milk for her family's use. This she did as the accepted thing to do to protect herself and her family from whatever hazards might lie in raw milk. She was city born and bred, and she was not too clear as to the nature of the hazards, but boiling was apparently supposed to remove them.

On a few occasions, when Bruce reached the farm, the day was hot. Inside the concrete milk-house, the coolness was delicious. Here he liked to pause, while the milk was being ladled out, chatting with some member of the farmer's large and robust family. One particularly hot day he sat awhile and drank some cool milk before leaving. A ladleful of fresh milk in the milk-house soon became a custom.

Typical of the infected city dweller, Bruce had contracted his illness while on vacation. But even those who never left the city were sometimes in danger. This was particularly true of packing-house workers, butchers, and veterinarians, who met with the infection in the course of their daily work. But, on the whole, Dr. Ross felt that rural populations contributed the greatest number of cases, since the reservoir of the disease was an infection of domestic animals. This presented a hazard to rural dwellers when they drank unpasteurized milk from their infected herds of cows or goats, or handled the infected tissues of cows, goats, and especially swine.

When the decision on the diagnosis

had been made, Bruce Malox came to occupy a bed in the hospital during his summer vacation. He was not too pleased with himself. The recollection of his visits to the farm in the previous summer was pleasant, and he could not truthfully say that he had had any hesitation in accepting the first drink of cool milk. He had, of course, been aware of some danger in raw milk but the robust evidence of the farmer and his large, friendly family was convincing enough to allay any doubts. He knew he had only himself to blame. So here he was, the voluntary victim of a poisoned cup, about to test the efficacy of aureomycin in a chronic case. Dr. Ross had given him no reason to hope that it would do any good. He was, indeed, not too pleased with himself and he was hardly in the mood to receive the clinic of medical students that the doctor had said he would bring.

Meanwhile, in the hallway, Dr. Ross was discussing Malox's prognosis with a group of senior medical students. "These chronic cases," said the doctor, "may continue for years as a marked inconvenience for the patient and his family but rarely threatening his life."

"Do they ever recover?" he was asked.

"Yes, with persistent treatment (or in spite of it!) the majority recover, sometimes after a short time, sometimes it takes several years. Actually, what we call recovery may be only a very lengthy remission between relapses. We cannot yet speak of cures in these chronic cases."

"Sir, do recovered cases show evidence of immunity?"

"That all depends on what we understand by immunity. They have clinical evidence of immunity by having apparently conquered their disease, but the laboratory may be unable to find a significant amount of antibodies in their blood serum. How well they could tolerate a re-infecting dose of organisms is a point I cannot answer. But some people must have resistance since the farmer and his family who drank the same milk as Mr. Malox seemed to enjoy perfect

health. We cannot even predict that Mrs. Malox and her baby would have become infected had they drunk the milk in its raw state. I think we have to admit that the problems of immunity in this disease are still largely unsolved, but we do not need to wait for these solutions in order to study better means of diagnosis and to reach a fuller understanding of the clinical features of the disease."

"If there are no other questions at present," continued Dr. Ross, "we shall go in and see Mr. Malox. Remember to deal cordially with him. Like so many cases of this sort, he seems a little put out with the world. Although he was responsible for his own infection—for he did know better than to drink raw milk—he is now inclined to think that he has already paid too much for his lesson. He is especially unimpressed by us. Since we cannot pull a ready cure out of a hat, perhaps he feels that he owes nothing to the sons of Aesculapius. And I cannot bring myself to blame him. Certainly, if I had *chronic brucellosis** I would feel much the same way!"

*Brucellosis (undulant fever) in man is a systemic or focal infection caused by *Brucella melitensis*, *Brucella abortus*, or *Brucella suis* . . . The course is of indefinite duration, but may be marked by repeated relapses and may become chronic. The mortality is low.—I. F. Huddleson in "Brucellosis in Man and Animals"

R. Chuckles P.R.N.

The type of joint movement involved when tilting the neck to look at the ceiling is reflexion.

Circumcision means drawing a large circle around a cut.

By depth of respiration we mean nearly at the bottom of respiration—i.e., the last breath.

In hypodermic medication prick a good fleshy part so you won't scrap the bone. Always hold the skin taut.

Evaluation of Schools of Nursing

SISTER DENISE LEFEBVRE, S.G.M., M.Sc.

Average reading time — 20 min. 48 sec.

HAVING PARTICIPATED actively in the program of evaluation of the Canadian Conference of Catholic Schools of Nursing, I shall discuss in this paper the purposes, values, procedure, and the results of this evaluation program. What applies here will also be true, in a certain measure, of any program of evaluation or accreditation.

PRELIMINARIES

For a number of years the Canadian Conference of Catholic Schools of Nursing had been studying the possibility of evaluating and accrediting our Catholic Schools of Nursing throughout Canada. After much preliminary work, this tremendous dream became a reality in the fall of 1946 when seven examiners visited 24 schools and presented a report of each visit.

These schools, located in 19 different cities, 8 different provinces, were under the direction of 19 different sisterhoods and represented a total number of 2,695 students. — REV. H. L. BERTRAND, S.J.

PURPOSES OF THE PROGRAM

The general aim the Conference had in view was to stimulate Catholic schools to achieve a progressively higher level of excellence. We considered the program as promotional work in the field of nursing education; so we did not hesitate to undertake it with all the work, risks, and responsibilities entailed.

We defined evaluation as a process by which an organization would, after visit, investigation, and report from an examiner, pass a judgment on the quality of the school's performance with reference to the stated purposes of that school. It was felt that this

evaluation was a necessary step toward accreditation since it was meant to secure factual information which would be used as a basis for accreditation when the program has advanced further and the Conference is prepared to assume the responsibility.

Our purpose as now set forth is not, therefore, as it would be in accreditation: to classify schools or to publish a list of those approved or accredited. It is rather to aid each school to remedy its weaknesses and strengthen its total program.)

The basic principles of our evaluation program lay in the fact that our schools claim to be Catholic, educational institutions preparing individuals for the practice of professional nursing.

As *professional* schools, we felt their program should keep pace with new developments without sacrifice of principles, apply the results of research to the care of the sick, and fulfil the social functions entrusted to a profession. It has been our hope that an effective evaluation program would be a means of helping our schools develop opportunities which would help them in raising the level of their professional effectiveness and in facing, with a certain amount of assurance, the present-day problems in nursing education.

As *educational* institutions, we thought our schools of nursing should adopt the objectives and techniques of general education in such phases as: faculty selection and preparation, curriculum administration, personnel activities, etc. The history of our schools shows, however, that they began on the apprenticeship system as aids to hospitals; therefore, they need stimulation and guidance in their educational endeavor. Then we asked ourselves the following question: Is the program of our schools of nursing adequate educationally to

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meet the need of the nurses of today? We cannot deny that there are in the organization of the nursing profession very marked changes, which are stimulated, some by social changes, others by normal progressive development. Our educational program must reflect these changes.

As *Catholic* schools, we agreed on the importance of the integration of religious teaching and viewpoints. The evolution of medicine and nursing has created new ethical problems and it is necessary that intimate relationships be emphasized between religious practice and professional life. Ideals are present in our schools of nursing; nevertheless, various circumstances prevent their full realization. It was the sincere hope that, through a program of evaluation, means would be found to overcome obstacles which, at the present time, retard their full development.

VALUES AND ADVANTAGE OF THE PROGRAM

When these were analyzed, they were found undeniable. We outlined them as follows:

1. The program would describe the characteristics of a school of nursing worthy of public recognition.

In all professional fields we feel the need of experts to judge the validity of individual institutions. Just so, it is necessary to protect society against incompetent schools of nursing. This can be done only if those who are competent to do so set down the essential features of a *bona fide* school of nursing.

2. It would become an outside stimulus to improvement. This is usually considered highly desirable.

3. It would aid administrative officers in their educational endeavor by promoting self-study and constant improvement and in protecting the integrity of educational programs from the encroachment of vested interests.

4. It would prevent academic stagnation through the continuous process of follow-up: yearly reports, studies in various areas, etc.

5. It would give a feeling of assurance to students and graduates because of their realization that their school is aware

of its obligation to exhaust every means of guaranteeing its product. It would thus raise the prestige of the school.

6. It would stimulate and encourage cooperation since the administrators of individual schools would become more conscious of the fact that they are working together toward a very important common goal.

7. It would be an excellent means of promoting an institution's specific purposes. For this the program was planned to recognize and give full weight to distinctive objectives, attitudes, and atmospheres of institutions; it thus preserves and encourages the wholesome opportunity for distinctiveness, initiative, originality, and experimentation.

8. It would be a protection against possible exaggerated government control and domination.

9. It would be a protection to the public at large. Nursing is concerned with the greatest values in human life. How disastrous could be the result of the mediocre training of a nurse! In many ways, a vast majority of people are at the mercy of our professional schools of nursing. Only if we take all effective means will we keep up the standards consonant with the high ideals proper to our profession and aid in the advancement of human welfare.

PROCEDURE FOR THE VISIT

Once we were convinced of those values and advantages a definite method of procedure was decided upon. The general plan of action was as follows:

1. The program of evaluation was offered to all Catholic schools of nursing in Canada who voluntarily decided whether or not they wished their schools to be examined and evaluated. I may say here that all the schools welcomed the program and the visit.

2. Examiners were chosen from among capable sister nurses who were given special preparation for their work.

3. A special committee was formed whose duty it was to study the applications and decide on the details of procedure.

PREPARATION FOR THE VISIT

Once the application from a school

was accepted, schedules of questionnaires were sent to the director of that school. The schedules are very important. It may mean work to fill them out but they are essential to a complete evaluation. They give the school an opportunity of analyzing its own program and it is an excellent preparation for all the faculty members and even the administrators for the survey by the examiner.

Other sources of information were also requested—the catalogue or announcement of the school, the annual report of the school and the hospital, the curriculum for the current school year, lists of personnel, faculty qualifications, etc.

PLANNING FOR THE VISIT

The completed schedules were received at least one week before the visit and were carefully studied by the examiner concerned. Any items needing clarification or amplification were noted.

The school was invited to review, before the visit, its own organization, administration, and curriculum, in the light of present-day standards and criteria in nursing education.

A tentative plan for the visit was then made.

THE VISIT

The visit included interviews, conferences, and observation.

In hospital schools of nursing, we felt it was logical to meet the *administrator of the hospital* in the first day of the visit. From her, we obtained an overview of the hospital and the school. We also observed her attitudes toward the school as an educational institution, the confidence she had in the director of the school, the authority she delegated to her, her interest in the school problems and in education.

The *director of the school* had the largest part of the responsibility for giving the information regarding the educational program. The schedules were reviewed with her and completed when necessary. A plan for the visit was made and, through her, appointments arranged with the various per-

sons concerned. The following points were discussed with her:

The purpose of the school.

The faculty selection, preparation, appointment, organization, and functions.

The general organization and administration of the school; the smoothness of its operation.

The functions of the board and of the various committees of the organization.

The delegation of authority and responsibility to the director.

The financial policies of the institution for the support of the academic program.

The adequacy of the physical plant.

The curriculum of the school, its character, and its relations to the purpose of the school.

Instruction in the school and methods for its improvement.

The relation of the school to the hospital. The quality of clinical resources.

The system of records and reports.

The sources and character of the student body; admission policies and recruitment practices.

The policies and practices in student counselling and guidance.

The plan for fostering investigations and study of institutional and educational problems.

Such an interview was meant to give the director an opportunity to interpret and help evaluate the educational quality of the school. She was expected to express her judgment as to the strengths and weaknesses of the educational program, its special contribution to nursing education, its needs and line of future growth and development.

Faculty members: The interviews with the other faculty members were concerned with their own fields of responsibility and functions. The competence of the faculty was observed in various teaching-learning situations. The results of instruction were indicated by students' ability to provide satisfactory nursing care and through various techniques, records, and reports.

These contacts with the faculty gave the tone of the institution; they revealed the degree to which the

faculty was aware of current trends in nursing education and new methods of teaching and of psychological management, organization of subject-matter, and examination practices.

Observation of the instructional facilities revealed whether they were adequate for the fulfilment of the objectives and for the carrying out of the educational program.

Visits to the departments of the hospital where students were receiving practice proved very valuable for a better understanding of the organization and administration of the hospital and of the clinical services; the standards of nursing care and service, the application of the principles of hygiene, the teaching of students and supervision of practice, the consideration of the patient as the centre of all activities.

The final conference was usually held with the members of the administrative and educational faculty present.

THE REPORT

Following the visits a descriptive, factual report was prepared for the schools by each examiner. This report had to be comprehensive in scope but concise in statement; it was based on the schedules and additional information gathered during the visit. It expressed the visitor's judgment as to the approval of the school; the strong and weak points of the program were mentioned. It contained definite recommendations based on the evaluation of all data obtained. What was considered essential or very important was indicated as such; details were treated as details. The reasons for the recommendations were generally explained or reference given to the report. It was required that the report be logically organized with headings and sub-headings as needed to make it clear.

In our evaluation program maps were used along with the descriptive report. Their purpose was to show the school its rank, order of excellence for each element examined, and also its standing with relation to the other schools of nursing.

BOARD OF REVIEW

The report was then presented to a Board of Review whose function it was to study the schedules, the summary, and the maps, and to give its final approval of the report. The latter was forwarded to the school with the proper recommendations.

Periodically shorter reports are requested from the schools visited and are used for follow-up. Schools also send in reports of new developments and progress as they take place. Changes are made accordingly in the file of that particular school.

RESULTS

In order to obtain an illustration of the general standing of the 24 schools, the scores given on each item were calculated, the statistical data compiled, and a graphic representation of the ranges and total averages prepared as shown in the accompanying chart.

No school was given a perfect score on any of the items. The highest score was allowed for operation and care of the school building. The lowest scores were given for budget administration, accounting methods, and vocational guidance.

The areas lower than the general average were: financial administration, library, and clinical instruction.

Relatively few institutions make provision for the financial administration of the school as such. The hospital usually assumes the financial responsibility. This area was evaluated on the following items: financial policies as related to educational objectives, budget administration, and accounting system.

Organization placed well below the average, especially for internal organization as concerns the efficient functioning of essential committees, the keeping of minutes, etc.

There are a certain number of very interesting and important points to note regarding the area of administration. Such items as admission, promotion, and graduation policies and procedures, conditions of faculty service, housing and boarding are scored higher than the general average, while records, especially clinical records, vocational guidance,

distribution of administrative, instructional, and personnel duties among the faculty members, professional interest and experience of the faculty are scored markedly lower.

When examined for holdings and use, as well as for effectiveness in the school program, the library received a low scoring. As this item may affect educational standards, it deserves our utmost consideration.

The personnel, facilities, methods, and records for instruction in the clinical field were, in general, in need of attention.

The physical plant of both the hospital and the school were quite adequate. Maintenance was also kept at a high level of efficiency.

The relations with the hospital were quite favorable.

The curriculum, as far as it was analyzed in the 24 schools visited, showed a growing awareness of the importance of this area in educational achievement.

Finally, it is gratifying to note that most of our schools of nursing have made sincere efforts towards achieving the objectives they had set forth.

CRITERIA USED

The following are the criteria used in evaluating each of the schools. The accompanying table shows the range of scores, mean and median on these criteria. (Mean X; Median I; Range—).

OBJECTIVES

1. Religious
2. Educational
3. Professional

ORGANIZATION

4. Corporate Organization
5. Internal Organization
6. Organization of Relationships
7. Organ. of Sch.-College Relation

ADMINISTRATION

8. Selection of Faculty
9. Professional Preparation
10. Experience
11. Professional Interests
12. Instructional Duties
13. Administrative Duties
14. Personnel Duties
15. Conditions of Faculty Service

16. Curriculum
17. Admission
18. Promotion and Graduation
19. Special Classes of Students
20. Academic Guidance
21. Vocational Guidance
22. Personal Guidance
23. Health Guidance
24. Student Health Guidance
25. Discipline
26. Spiritual Group Guidance
27. Spiritual Individual Guidance
28. Records and Reports
29. Recording
30. Special Activities
31. Housing
32. Administration of Boarding

FINANCE

33. Financial Policies
34. Budget Administration
35. Accounting Methods
36. Financing Supplem. Activities

RELATIONS WITH HOSPITAL

37. Rel. between Sch. & Hosp. Person.
38. Adc. of Census for Sch. Program
39. Hospital Organization
40. Quality of Medical Care

PHYSICAL PLANT

41. Hospital
42. School of Nursing
43. Op. and Care of Hospital Bldg.
44. Op. and Care of School Bldg.

CURRICULUM

45. Objectives and Organization
46. Techniques of Curriculum
47. Courses
48. Nurs. Content of Curriculum
49. Basic Science Course
50. Cultural Course
51. Course in Nursing
52. Another Course in Nursing
53. Course in Ethics
54. Course in Religion

INSTRUCTION

55. Institutional Concern for Instruc.
56. Methods
57. Facilities
58. Effectiveness

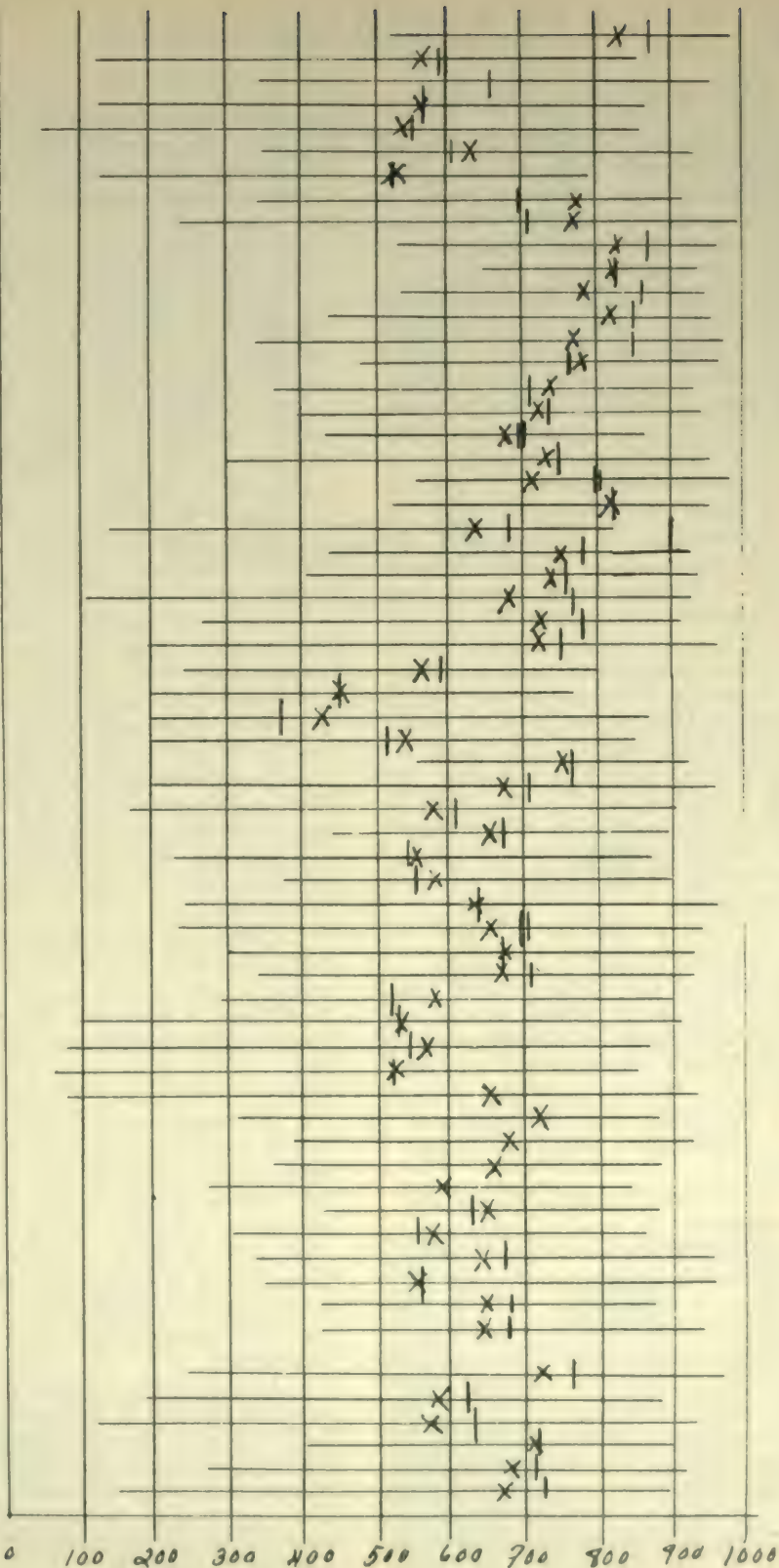
LIBRARY

59. Library and the School
60. Holdings and Use

EDUCATIONAL RESULTS

61. Examinations
62. Placement
63. Professional Certification

63
 62
 61
 60
 59
 58
 57
 56
 55
 54
 53
 52
 51
 50
 49
 48
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EVALUATING THE EVALUATION PROGRAM

Improvements in schools: As a result of the evaluation program many improvements have been observed in our schools of nursing—in those visited and also those expecting the visit. One school closed its doors because it felt it could no longer meet its objectives; some have enlarged their educational program, opened their libraries; others have encouraged the preparation of faculty members; still others improved their program of clinical instruction, etc.

We found differences in institutions. Some were superficial and had no significance in determining the educational quality of the school. Many of the variations noticed were educationally sound and will be fostered; choice of teachers, of textbooks, differences in students' personnel service, source of financial support, extra professional activities, physical plant, differences in organization and administration, etc. The question we asked ourselves was: Is this plan or program conducive to the achievement of the purposes of the institution? Or is it an obstacle to such achievement?

PREPARATION OF EXAMINERS

Because of the complexity of evaluation, we were further convinced of the importance for the visitor to be qualified both educationally and professionally. We felt that she should:

1. Be familiar with the principles of good administration, teaching, and supervision.
2. Know what is essential for a school to possess and the areas to be evaluated.
3. Have the ability to interpret objectively and to express herself clearly in writing.
4. Have a clear understanding of the purposes of evaluation.
5. Possess qualities of leadership if she is to help on counselling.

Inexperienced persons should be trained before they attempt visiting and evaluation.

HAZARDS OF THE PROGRAM

During the process of evaluation

we discovered certain errors which could easily be made at the beginning of such a program and which might prove disastrous if not avoided.

The following cautions are, therefore, presented:

1. It should never be our purpose as an evaluating or accrediting agency to take control of the institution. Our sole responsibility is to pronounce on the quality of the program which is to ensure the quality of the product.

2. A standardized plan should at no time be imposed on any school. It may simplify training for a profession if we cast all in the one mould but "it reveals the mind of the filing clerk who objects to business which does not fit the system." Initiative in details of administration should reside with those responsible for the conduct of the school. Experiments, when they are sound educationally, should be encouraged. A regimented curriculum with detailed prescription of content in nursing education, as in any professional education, could become a great danger to initiative, experimentation, and progress. There are, unquestionably, certain basic knowledge and techniques which every nurse should command, but there is no single way of achieving this.

3. Care should be taken that idealism and inexperience do not lead us to the setting of unreasonably high standards. In all areas of education, there is, and always will be, over and above the essentials, a great diversity of levels, according to objectives, clientele, etc.

4. We should guard against discrimination in the various sources of financial support for the school of nursing. Given the facilities to conduct an acceptable educational institution and the requisite funds, it should not make any difference in the quality of education where these funds come from, whether from a donation, the government, the hospital, or any other agency.

5. Another danger would be to try to move too fast and be intolerant of the institution which shows the gradual and normal development that comes from thought, discussion, and guidance. Hasty action could cause the defeat of ends which would have been achieved with a little time and prudence.

To conclude, I cite the words of Rev. Father Mallon, S.J., in his article on "Accrediting of Professional Education," published in *The American Journal of Nursing* in Nov. 1948:

A hazard to accreditation in the field of nursing may be in a program which divorces the course from actual nursing. Clearly academic training is tangible and will submit to criteria to measure its quality. Bedside service to the ill must be the real objective of nursing education, but it is not equally measurable. There is

hazard, too, necessarily, in the fact that in most professional fields the people who have the background and idealism to lift the profession higher are also too often people whose immediate practice of the profession is a thing of memory.

To me, it would be a tragedy to humanity should the vocational aspect of nursing, the care of the sick, be lost in a maze of academic standards and norms which have no valid reason for existence except in the interests of the care of the sick.

Ambulance Duty

JOAN AINSWORTH

Average reading time — 5 min. 36 sec.

THE BERMUDAS are a group of about 300 coral islands, two of which were joined together in the building of an American base during the war. They are situated some 750 miles southeast of New York in the Atlantic Ocean and are said to be the most northerly coral formation in the world. To Canadians they are most familiar in advertisements as a winter playground.

I remember how, as a student nurse in Montreal, I used to walk past a travel agency in whose windows were displayed pictures of Bermuda. Viewing all the snow and slush around me, and feeling the biting wind, I used to long for the brilliant skies, gaily colored houses, and magnificent hues of the Bermuda waters. To describe Bermuda as the "Isles of the Rest" was far from the truth, as one, who had lived and worked at the King Edward VII Memorial Hospital for one year as a student nurse, knew only too well!

The area of these islands is about 20 square miles. The population of approximately 35,000 includes European, Negro, and Portuguese. This

does not include a fluctuating tourist population averaging 38,000 per annum. All this information probably seems highly irrelevant to the title of this article, but wait a minute! As in any other community, there is the usual quota of illness, accidents, and other emergencies to be encountered, but the transportation problem of these islands is unique and demands a constantly available Ambulance Service. There are approximately 300 miles of macadamized roads, as well as those known as tribe roads—which are often narrow, uneven tracks, which somehow or other the ambulance drivers seem to negotiate.

The King Edward VII Memorial Hospital owns and operates two am-



Ready for a call

Miss Ainsworth is currently enrolled as a student with the McGill School for Graduate Nurses.

bulances, each specially constructed on a Ford chassis. The interior provides an adjustable stretcher and side chairs for nurse and relative travelling with the patient or, if from the hospital, another ambulant patient. In addition, there are cabinets containing drinking water, paper cups, extra blankets, gowns for nurse and patient, "celluwipes," kidney basins, etc., and a small oxygen tank with funnel apparatus. There are also two bags, one fully equipped for surgical emergencies, containing:

Packages of surgical dressings, dressings, swabs, rubber tourniquet, roll 1" adhesive, mouth gag, 2" and 3" bandages, medicine glass, minim glass; bottles of brandy, alcohol, iodine 2½%, mercurchrome 2½%, aromatic spirits of ammonia; hypodermic syringe with 2 needles, files, bowl, kidney basin, scissors, 4 straight forceps.

Drugs: Camphor in oil gr. 3, adrenalin, strychnine sulphate gr. 1/30, digitan, pitocin, coramine, morphine sulphate gr. ¼.

The other bag is fully equipped with all necessary articles for a delivery and contains:

Kidney basin, bowl, 3 O.R. towels, packages of dressings and of swabs, medicine glass, 3" bandage, perineal pads, two pairs of rubber gloves (sizes 6½ and 7½), cord ties, hypodermic syringe and needles.

Drugs: Ergot, pituitrin, morphine gr. ¼, coramine, camphor in oil, strychnine gr. 1/30, alcohol, fluid extract of ergot, silver nitrate, Dettol, soap.

Instruments: 2 pairs artery forceps, 1 pair tissue forceps, scissors, chloroform, chloroform dropper & mask, thermometer, padded tongue depressor, caps and masks.

It is surprising how often this bag is put to use. I have even known the first baby of one of the loveliest pairs of twins I have ever seen to be christened "Mike," after the Portuguese driver on whose shift his precipitous arrival occurred.

In one of the lockers also is a sheaf of ambulance slips which the nurse fills out before returning to the hospital. Much time is saved and assistance given the doctor if these slips

are filled out correctly, particularly in an accident or in the case of transporting an unconscious patient.

The ambulance staff consists of two Portuguese drivers plus an auxiliary driver. These men work in shifts—24 hours on, 24 hours off duty, from 8:00 a.m. On every call the driver is accompanied by a nurse and an orderly to assist with the stretcher and any heavy patient. Generally, the nurse is from the out-patient department which receives and despatches all calls, but occasionally the call may be taken by a nurse on the ward. All obstetrical calls are taken by nurses from that department and a nurse from the isolation division accompanies patients to and from this unit. After five years of working with these drivers, I feel convinced that the Canadian nurses employed on the staff of the hospital are given a better sightseeing tour on ambulance duty than any offered by a carriage or taxi driver. Camera fans have often gone back on their bicycles to obtain a delightful snap of "local lights" and places no tourist would normally visit. To many nurses, the names of persons and places must seem confusing, as indeed it is, with the different races included in the population, and where there is a fairly high percentage of illegitimacy. As one who has now lived and nursed among these people for a considerable time, I find myself saying "Are you a Simons from Somerset?" etc., and have, in many cases, cared for several generations of the same family!

Bermuda depends to a considerable extent on her tourist trade. These visitors are subject to the same illnesses and perhaps are more prone to accidents due to their inexperience in the management of a bicycle!

We all know how helpless and dependent we become in time of sickness. To be taken to hospital during what should have been a wonderful vacation must tax an individual's emotional make-up to breaking point. Seldom does a ship dock here without leaving a passenger or member of the crew behind for

(concluded on page 296)

Private Duty Nursing

My Feet are Killing Me!

GRACE KELLY

Average reading time — 4 min. 48 sec.

ONE OUT OF EVERY THREE persons complains about aching feet. Women are more prone to pedal ills than men in a proportion of four to one. Recent studies have shown that 70 per cent of upper grade school children have feet that require attention. Many of these are the girls who will later be applying for admission to our schools of nursing. Since the cause of most of this discomfort lies in the fit of the shoes they wear, nurses have an obligation to wear properly fitted shoes themselves and to encourage parents to see that their children are suitably shod.

Up to the age of seven, a child outgrows its shoes before it outwears them. At adolescence the feet grow even more rapidly. A twelve-year-old's feet, for example, may grow from one to three sizes every 12 to 16 weeks. The 26 bones that comprise each foot do not reach their maximum development until about the age of 20. Yet their delicate, complex structure is one of nature's wonders since these bones are subjected to thousands of pounds of pressure daily.

RELIEF FOR ACHING FEET

Most nurses have experienced a luxurious feeling when they get home, take off their shoes, stretch their feet and wiggle their toes. According to the foot specialists, that is the basis of the best possible exercise for aching feet. Toe curls can be done sitting, standing, or bucking the crowd on the home-going bus. Keep curling and uncurling your toes, stretching them

as much as possible each time.

Foot flexing is another boon when legs are cramped or painful after a switch from high to low heels. To get maximum relief, sit on the edge of your bed with your shoes off, extend your legs, and flex your feet up and down as far as they will go each way. The pull in the calf muscles indicates how stretching brings muscle tone back to normal.

Podiatrists also prescribe another simple exercise for feet that are tired after a day on duty. If painful adhesions have formed from wearing shoes that look better than they feel try this toe exercise: grasp the big toe between thumb and forefinger and move it in a circular direction. This simple exercise helps prevent bunions and relieves stiffness in the big toe joint.

A daily foot plunge in tepid water,



Tepid foot bath

The material for this article and the illustrations were contributed by the Sole Leather Bureau of New York.



Be measured standing

with a teaspoonful of epsom salts added, will relieve tired tendons and aching joints. It's also quick relief for ankles that are puffy after an especially busy day.

DOES A SHOE FIT?

Get a picture of the condition of your feet by examining your shoes. Look at the bottoms first. If the wear covers the entire sole area, with the greater wear evident along the margin of the sole, the shoes fit correctly. The heel, also, should be worn down along the outer side. These are the areas that receive the greatest thrust of body weight under normal conditions.

If the forward portion of the sole shows excessive wear, the shoes are too short. Toes are being cramped. This will affect gait, posture, and may be the root cause of back pains later.

Is wear especially heavy on the inner border of the heel and on the inner margin of the sole? If so, chances are that the upper is misshapen, too, with the inner side bulging unnaturally. This all adds up to pronation—the forerunner of flat feet. Again, the source of the trouble is shoes that don't fit but the remedy may call for a visit to your physician.

CHILDREN'S FEET

A survey of foot specialists revealed

their concern with three tendencies in the care of children's feet:

1. The fitting of children with hand-me-downs discarded by their older brothers and sisters. Doctors warn against this practice, which disregards the fact that children's feet are malleable and will go any way they are pushed.

2. The widespread use of sneakers for everyday use. Officials of the Podiatry Society warn that sneakers and many popular loafer shoes provide insufficient support at the instep. As a result, weight is distributed wrongly and weak feet and, eventually, flat feet may develop.

3. Directly tied up with the use of sneakers is the lack of public education regarding the dangers of wearing shoes with impermeable materials. Children and adults need plenty of ventilation for their feet to prevent the development of fungus infections and other ailments resulting from the use of shoe materials which neither allow the passage of air nor absorb perspiration. It is this consideration that led the National Foot Health Council to recommend leather soles. The fibrous structure of leather allows passage of air in and out and provides necessary air-conditioning.

BUYING SHOES

Foot specialists have pertinent things to say about shoes. First, all footwear must fit properly. This rule starts with the first pair of shoes parents buy for a child and lasts a lifetime. Never try to force your feet into shoes even half a size too small. In buying shoes for children the rules to follow are: Measure the child's feet every time new shoes are bought. Fit the larger of the two feet. Never be guided by the size of the last pair of shoes.

For school shoes, authorities recommend oxfords at least four eyelets high, with supple uppers and flexible leather soles that bend with the foot. The shoes should have a firm counter at the heel to hug the foot. They should be wide enough to allow the leather to be pinched together between the fingers and long enough to provide three-quarters of an inch between the longest toe and the tip of the shoe.

In respect to her own shoes, every

nurse should discover the style that suits her particular needs, both for duty wear and when off duty. Since her livelihood depends to such an extent upon foot comfort, extremes in design should be rigorously avoided. When she finds a last that suits her foot, it is well to stick to it even

though she may crave some of the less substantial looking shoes that are offered. For perfect fit, buy your shoes towards the end of the day and have your feet measured when you are standing up. Leave high heels for gala evenings and stick to medium heels for duty wear.

In The Good Old Days

(The Canadian Nurse, April 1910)

"We are now assured that it is not possible, as was once thought, that cows, drinking water infected with typhoid bacilli, can transmit the bacilli in their milk."

* * *

"A new form of fever has been rife among us and we are only now in the development stage with occasional characteristic rises in temperature whenever fresh news arrives of new marvels in aeronautics . . . Some ladies fell victims to such an acute attack of aviation fever and were persistent to the extent of audacity in the attempt to induce an aviator to take them for a flight . . . It is amusing to hear that 17 years ago orders were issued at Washington in the Patent Department that airships and perpetual motion machines should be classed together and patents refused, as such were considered absolutely impracticable."

* * *

"In Montreal, school nursing and tuberculosis class work conducted by the V.O.N. are showing good results. Two nurses work especially among tubercular patients."

* * *

"Hospital social service work . . . had

its beginning in the Johns Hopkins Hospital eight years ago . . . It was Dr. Cabot, of the Massachusetts General Hospital, who first established the department as an integral part of hospital equipment about five years ago."

* * *

"The Halifax Children's Hospital is doing splendid work. It is now caring for 17 little patients."

* * *

"Miss Clark, of the Presbyterian Hospital, New York, has been appointed Lady Superintendent of Hamilton City Hospital at a salary of \$900 per year."

* * *

"According to the Government Inspector's report for the past year the expenditure for the support and maintenance of the hospitals of Ontario was \$1,594,750. This indicates a spirit of philanthropy that speaks well for the Province."

* * *

"The Calgary General Hospital . . . reports that the cost of maintenance per patient was less per day, being \$1.20 for 1909 as against \$1.35 for 1908."

Fluorides

The importance of fluorine in preventive dentistry is now acknowledged. Current interest centres on the presence or addition of fluorides in drinking water and tends to obscure the fact that foods also furnish dietary fluorine . . . Seafoods contain more fluorine than any other food except tea . . . Tea is very high in fluorine—75 per cent or more is extracted by boiling water. The

hot water extract of one tea-ball may contain 0.1 mg. of fluorine.

The fluorine content of cow's milk is not affected by the fluoride content of the cow's ration or drinking water. The content in citrus fruits is less than 0.1 part per million. Common cereals . . . are extremely low . . . Most fresh vegetables range from 0.1 to 0.3 p.p.m. on a fresh weight basis.

—*Nutritional Observatory*

Institutional Nursing

The Nurse and the Rural Community

SISTER STELLA M. DUBE

Average reading time — 8 min. 36 sec.

IT HAS BEEN my good fortune to have been stationed for a number of years in a small rural hospital and to have had the enlightening experience of seeing the influence such a hospital can have on the surrounding district. A small rural community has few possessions so these few it takes to its heart. Often, the hospital is the only possession and its solitary position of honor gives it a standing quite out of proportion to its size.

I view with a considerable feeling of regret the present-day tendency of building in the large urban centres and away from the small rural areas. It is a pity that we are getting away from the rural people who will always be the backbone of a nation. It is true that certain advantages accrue from this concentration of service in the larger areas. It is often a necessity, too, as it affords the selection of the best in special services, technique, and equipment for schools of nursing. But I make bold to assert that the small rural hospital has possibilities of creating a good community spirit, not given to the larger institutions.

The small rural hospital belongs to the community which is fortunate to possess one. It soon becomes an integral part of the village or town where it happens to be. The local interest it creates can develop among the residents of the district that characteristic quality, known as a *good community spirit*. Whether that community spirit will continue to deserve the descriptive word "good" will depend in a large measure on the nursing personnel of the small rural hospital.

In speaking of a hospital, I am considering, of course, its soul, as well as its body. In this age, the inclination is often to give first attention to the body. We are often more concerned with the type of building, the furnishing and the equipment than we are with the soul of the hospital—the doctors and nurses who operate it. Stone, wood, and metal can bring small comfort to the sick and the weary unless their use is directed by fully developed human personalities. It is that human personality, the nurse, who is the subject of this paper.

Questions stimulate thought, they contain an open challenge and, at times, a silent reproach. To the questions: "What is the position of the nurse in the rural community? What should she give to the rural community of which she forms so important a part?", the answers come swift and certain. Her position is that of a leader. She should give to the community all that she has.

The nurse is a leader. In what does her leadership consist? Not necessarily in appearing on public platforms or in the public press. Her leadership, generally, will consist in the influence she exerts on the little world with which she is in contact. If her influence is to be of value to those with whom she deals, she will have to develop and maintain the fine Christian qualities of a true woman—kindness, mercy, generosity, sympathy, zeal for her work, nobility of thought and act. These lacking, all the professional skills in the world will not make her a nurse in the ideal sense of the word. She may be able to heal the wounded limb but she will not be able to soothe the overwrought

Sister Dube is superior at Our Lady's Hospital, Vilna, Alta.

mind of the worried, nor awaken the flagging courage of the depressed, nor bring back the smile of contentment to the face of a frightened child. A nurse is more than a soulless expert, making beds and applying medications. She must show by the radiance of her virtues that she is a complete woman, spirit as well as flesh.

It is true that the nurse is called upon to give much of her time and energy in her arduous service to the community in which she lives. To some, it may seem that to go to work in a small rural hospital is the killing of oneself for others; a burial of one's hopes and ambitions. This is far from true. If nurses-in-training could be given two months' experience in a rural hospital before they graduate there would exist among them a greater understanding of the problems, the compensating joys, and the minor sorrows of the rural hospital and the rural community; and a greater willingness to devote part of their life to this important section of our country.

We make our world and carry it on our back. The great business in the life of a nurse is to be and to do and to do without. Never has there been more discontent than there is in certain sections of the population today and never more leisure and more material wealth been found among these people. The nurse must learn to be satisfied with less of the material in order to enjoy more of the goods of the spirit. The greatest thing the nurse needs is zeal in the carrying on of her chosen profession. It is easy for the spirit to lag and, after awhile, die out. Most of us know how close is the border line beyond which our work becomes a chore. Conditions are not always (I should be honest and say they are never) perfect. If the doctor proves to be a model of his profession, then the handy man is "like a long headache in a noisy street." If these two important members of the hospital staff are all that can be desired, then there remains the maid problem, or the shingling problem, or the lighting problem, or the power problem, or the

thousand other problems that I could describe in detail. In the midst of all these human upsets, the flame of inspiration must be kept alight, the ideal must not die down. The nurse must train herself not to permit the power of circumstances and persons to affect her to the point of discouragement and to murmur, "Is it worthwhile?"

The life of a nurse is a glorious career, considered even from the national standpoint. It is a life of service to her beloved country. Those who help build up the minds and bodies of the weak and ill are performing a task of tremendous importance for any nation. Just to imagine the country without nurses for one week gives sufficient food for thought as to the value of the nursing profession to the nation in general and to the local community in particular.

In the rural district it can hardly be otherwise than that nearly every member of the community, at some time or other, has been a patient of the hospital. How much fear is disguised by the patients and relatives—fear of the unknown? To establish the patient in quiet of mind, and also the patient's relatives, is a task and a duty confronting the nurse. She must act in the capacity of a public relations officer for her hospital. This will not be difficult if she has cultivated a warmth in her heart and a cordiality in her manner of greeting. When the new-comers are met with the friendliness and sympathy that the welcoming nurse knows how to extend, their instinctive dread of the hospital, as a place of bleakness, coldness, and aloofness, disappears. In the small hospital the doctor and nurses form a unit for the common care of the patient. The family spirit, the informality, and personal interest in each patient as a member of the same small community create a relationship between staff and patient that does not weaken when the patient is discharged.

Members of the rural community, on their visits to the hospital, should see the nurse as "a lovely light in

every room." She should breathe the spirit of kindness and sympathy and mercy. Nurses have always made sacrifices for their profession and often the greatest sacrifice and the one that yields the greatest returns is that of self-discipline; the care of the sick, when done conscientiously, can never be an easy task. The fundamental purpose of nursing is to make the patient comfortable and to aid the physician in applying every known therapeutic measure for his recovery. In doing this, she is only being just, for justice demands that the patient receive the best possible care.

In the small hospital the nurse has an excellent opportunity, at times, of giving psychological help to a soul tried by sorrow as well as physical pain. All spiritual values seem to have dissolved and disappeared. The nagging thought that nobody cares can worry a patient into a greater than physical illness. The nurse can be an escape valve for the pent-up emotions of the patient. If she is a wise and well-developed personality, she can offer constructive advice and consolation. Every need is an opportunity and every opportunity is a responsibility. There is created between a good nurse and a patient a bond of understanding which makes for sympathy and a desire to be helpful on the one hand and an eagerness to share one's troubles and receive advice and help on the other. The problems that worry or puzzle a patient may seem of little moment to the nurse—perhaps it is the question of feeding the older children or of caring for their minor ailments. An alert nurse will not let the occasion pass without making sure that the mother goes home with a good knowledge of how to handle her little problems. Or it may be the mother with her first-born awed by the task of preparing a formula. The wise nurse will see that the mother knows well how to do this before she leaves and not only that she knows how but that she carries with her on her long trip by wagon sufficient for the baby's first feeding. How great will be the appreciation of the mother, after the

weary journey, to have only to heat the formula! It gives the mother that breathing space we all appreciate.

In addition to the contacts with the patients and the patient's friends, there is also the women's auxiliary to deal with. This relationship can be very pleasant and profitable both for the individual nurse and for the hospital as a whole. A group of friendly, rustling women, engaged in conducting teas or bazaars to help the hospital make ends meet, is an encouraging sign of healthy and happy relations between the nursing staff and the district. We are told that if we want to make a friend of a stranger let him do a favor for us. There is no surer way of making friends for the hospital than by encouraging the women's auxiliary in their projects.

The nurse will not taste real happiness until her giving excels her taking; until she is more concerned with what she can do to help others than with looking to others to help her. The nurse, who has learned to adapt herself to the needs of the community, can take the situation as she finds it—mould it to her own ends and produce a worthwhile work no matter how small a sphere it be. In her capacity as leader in the community, the nurse can find numerous opportunities for instruction in hygiene. Groups are always to be found who are ready to attend classes in home nursing, first aid and emergencies. Classes, too, in prenatal care are eagerly looked forward to by expectant mothers. The nurse will find herself so occupied with the interests and problems of the district that she will look with surprise at the questioner who asks: "Don't you find it lonely in that isolated district?" Many forget that life is largely what we make it. In the hospital, as outside, we live to learn; we are learners all our lives. And the knowledge that service for others brings with it a recompense in the form of quiet contentment is a lesson that the nurse soon makes her own. The compensating satisfaction of activity can be found in several ways—in the inspiration of service to one's com-

munity; in the inspiration of service to one's neighbor; and in the inspiration of service to Him who said, "In-

asmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."

A Dream Come True



For years, we had planned, prayed, hoped—and almost despaired—of obtaining suitable accommodation for our student nurses. So February 2, 1950, was a red-letter day in the history of St. Mary's Hospital, Montreal, when the new five-storey nurses' residence was officially blessed and opened by His Excellency, the Most Rev. L. P. Whelan, Auxiliary Bishop of Montreal. Mr. J. J. Gallagher, president of the Board of Directors, welcomed the guests and expressed appreciation to all who in any way have contributed towards its erection. His Excellency asked God's blessing and protection on the new building and inspiration for its teachers and students.

Following the ceremony, tea was served on the mezzanine of the hospital.

"Open House" from 4:00 p.m. to 9:00 p.m. provided an opportunity to the public for visiting the residence. The living-room, where the accompanying scene of relaxation occurred (no, it isn't a bedtime story!)

is on the main floor and has been artistically furnished by the Ladies' Auxiliary. It is hailed with joy by the students and their visitors. There are 68 single and 20 double rooms furnished in blue and rose furniture, with colorful drapes and an easy chair in each room.

The informal sitting-room and adjoining kitchenette is one of the most popular spots in the whole residence. Thanks to the alumnae association of our school of nursing, it has been possible to furnish this with attractive red and black chrome furniture—plus everything that makes for convenience and comfort. The classroom, offices, and library, as well as sewing, laundry, linen and storage rooms, complete the building. A roof garden is beckoning very invitingly but, until the weather permits, we view it from a distance only.

SISTER MARY FELICITAS
Director of Nurses

Organisms multiply rapidly if not arrested. The thoracic duct controls all thoughts and sensations.

You mechanically remove food from microbes when you wash a rubber pillow-case.

Rectal temperature is most accurate because it is taken in a closed vessel.

When the arterial wall will not contract and expand as much as usual it causes tension.

Public Health Nursing

The Agency's Part in Planning a Student Program

KATHERINE M. WEATHERHEAD, B.S.

Average reading time — 7 min. 12 sec.

THE GREATER MONTREAL BRANCH of the Victorian Order of Nurses is one of 110 affiliating branches of the Victorian Order of Nurses for Canada. This branch is divided into five territorial districts. Each district has a supervisor, from 10 to 12 staff nurses, and a full-time clerical worker. We offer planned experience during May, June, and September to university students enrolled in public health nursing courses. This article is a report on the program which our agency has for public health nursing students.

One of the first steps in planning the program for the students is to determine, with the help of the district supervisors, the number of students to whom we are prepared to give this experience. As soon as the university faculty are able, they submit a list of the students preparing to come to the V. O. N. with a short account of their previous experience.

The Montreal branch asks that the student define in advance what she expects to get from her field experience. These objectives differ a great deal with the fall and spring groups. They differ, too, on the basis of previous professional preparation, experience, interests, and needs. At the end of two weeks, the objectives of each student are reviewed in relation to the experiences she has had and those which she still needs. This is done in conference and the discussion of a given objective brings to light many different experiences from the group. At this conference, the student

is expected to tell the group some of her problems in planning, conducting, recording, and evaluating one home visit she has made. She may be asked to relate some experience in working with a member of staff to plan her day's work. She might tell the group of some knowledge she has gained in working with another community agency. At this time she is better able to understand how she can use her guide nurse and supervisor to advantage. We shall refer again to the use of the student's objectives when we mention the post-field experience conference.

The selection and preparation of staff nurses for guidance is carefully considered by our supervisory group. We aim to have an experienced nurse interpret public health nursing. She should have demonstrated her ability to work effectively and have a thorough knowledge of her district and the families in her area. We try to select a nurse who enjoys sharing her field visits with the student. After the selection of nurses for student work is made, the proposed program is presented. Following its approval, a copy of the program goes to the university.

A special conference is called for the field guide nurses in which we discuss the program for the students. We review the purpose of our conference, discuss our objectives for this field experience, and mention pitfalls we might avoid based on suggestions from supervisors, field guide nurses, students, and the educational director. It might be of interest to relate briefly the purpose outlined in our conference last August and some of the discussion that took place.

Miss Weatherhead is educational director with the Greater Montreal branch of the Victorian Order of Nurses.

We considered our previous field program for post-graduate students and discussed suggestions for changes which had been submitted. We agreed that the changes suggested were reasonable and would strengthen our student program.

We considered the importance of the staff nurses' contribution to the success of this experience—e.g., nurse attitudes and relationships within the agency, relationships with other community workers, and with families. These were considered part of the staff nurse's responsibility for interpretation. At this time a suggested bibliography was given to the field guide nurses. This was composed of the most recent articles on human relationships and the public health nurse in the community. Reference was made to a recent bibliography sent to each district office which might be of great assistance to the student in her field work. This bibliography was compiled with relation to types of illness with which we deal constantly. Included were recent articles on: cancer, arthritis, heart conditions, hemiplegia, diabetes, multiple sclerosis. Included also were articles relating to hospital referrals and home care.

We discussed some of our detailed objectives for student experience. Some of these were:

Interpretation to the student during her experience of the functions of the V.O.N. and some of its principles and policies.

Understanding of the need for co-operative thinking, planning, and doing by all groups interested in the community welfare.

Practice in visiting nursing in order to adapt hospital experience to the home situation.

Some appreciation of the use of statistical data, the changes in service according to the need in the district.

Acquisition of some knowledge of people of the community in their own homes in order that she may have a better appreciation of their social and health needs.

Development of some confidence in planning the day's work, bedside care of

the sick in their homes, individual health teaching, recording, reporting, and referring.

We feel that continuity of work with a few families developed greater understanding than short contacts with many.

We reminded ourselves that long after we had forgotten the details learned in our field experience, we remembered our relationships with our field guide nurse, something about her general philosophy and understanding. Student observation of how her guide nurse managed her district forms a lasting and influential impression.

The amount of class work is kept to the standard suggested by Violet Hodgson of three to five hours a week. The morning the students arrive, they are welcomed by the district superintendent, who speaks to them on the history of the V. O. N. and discusses the function of the National Organization as well as that of the local branch. Other classes given are:

Those relating to bag and thermometer technique, home visiting, recording, setting of fees, inter-agency co-operation, and the importance of our part in the referral system for continuity of care; the prenatal visit; the post-natal and demonstration bath visit; body mechanics in nursing activities; and bed positions with the long-term illness patient.

The field guide nurse will review with the student all pertinent information that would have a direct bearing on planning the care of the family. It is important, too, upon the completion of a visit, for the student to have a conference with the supervisor to analyze and evaluate the visits and make tentative plans for the future. In order that she may become acquainted with her supervisor, guide nurse, and the staff in the district office to which she is assigned, the student goes to her district on the second morning with the agency.

The student has an experience sheet on which she keeps a cumulative record of her experience in the field with comments. This record is written up daily so that at the end of her experience she is able to write her

evaluation based on factual information. This experience sheet is the property of the university.

By her independent visits the student gains experience in entering homes and giving necessary service. She has an opportunity to test her ability, discover strengths and weaknesses, and is encouraged by her field guide nurse to ask for further observation and assistance when she needs help. By the end of the third week the student, with no previous experience in district nursing, is developing a certain amount of independence and self-reliance. She discovers health and social needs through direct contact with patients and families and observes the experienced nurse's skill in helping families to meet these needs.

Planned observation visits are arranged periodically with the student during the month by both the guide nurse and supervisor.

Although our larger staff conferences are held only four times a year, our regular in-service program overlaps a little to provide this type of observation for all our university students. Some of our districts commence this program in September and carry through until April. Others commence in October and carry through until May. Students are instructed in the way in which we plan our staff education program. Each district suggests in the late spring the areas of interest for an in-service pro-

gram in the fall. Early in the fall this is followed through so that each district is organized and is prepared to study along the lines of greatest need for help in their particular district. We hope the student acquires some appreciation of the direct relation of education to service by this observation.

Before the student's last day with us she selects one or two of the objectives submitted prior to her field experience. She is given time for preparation and is asked to think about the families with whom she has been working during the past month. She comes to the conference, on her last day with the agency, prepared to give the group a concrete example of how she was able to meet the objectives selected. This very often requires help from her guide nurse and supervisor.

The staff member from the university, responsible for field experience, sits in at this post-field work conference. The student is encouraged to offer any suggestions which might make field experience more helpful for others.

We keep an open mind for a constantly changing program based on suggestions from those concerned. We hope that the time spent in student experience with the Montreal branch of the Victorian Order of Nurses will stand her in good stead as she begins her new work in public health nursing.

Ambulance Duty

(continued from page 286)

medical treatment. Very often patients are embarked who are going north for specialized medical care not available on the islands. A quietly poised, sympathetic, and understanding nurse can do much to reassure the patient and give him a feeling of confidence in the hospital. The ambulance nurse, therefore, should think well of the responsibility she bears, to both patient and hospital, for it is through her the patient is afforded the

first opportunity of judging those who are to be responsible for his care.

The nurse's office, as Lord Moy-nihan, the famous surgeon, once said, is "to be ready in all emergencies, quick and competent for action, courteous in speech, considerate in thought and a comfort in hours of sorrow." How important are these qualities on ambulance duty, as you climb in beside the driver to his familiar words of "Come on—let's go!"

Aux Infirmières Canadiennes-Françaises

L'Infirmière en Service Industriel

EVELYNE GAUVIN

Average reading time — 10 min. 24 sec.

"IL FAUT ÊTRE DE SON TEMPS." Peu importe qui l'a dit, mais l'infirmière en industrie est peut-être une des mieux placées pour constater à tous les jours la vérité de cette maxime. Or, la pensée moderne et actuelle sur le rôle qu'elle a à jouer implique que c'est affaire du passé, une salle d'urgence pour les seuls blessés de l'entreprise où elle exerce ses fonctions; ou encore une organisation insuffisante que la clinique pour les malades seulement; banale salle de repos aussi, que celle où l'on accueille sans discernement flâneurs ou fatigués, anxieux ou amusards.

On aura vite compris que l'infirmière est devenue agent de santé, non seulement *garde-malade mais garde-santé*, en prévenant ce rôle-là par celui-ci. Chez un personnel d'ordinaire bien portant, parce qu'embauché après un examen médical satisfaisant, elle aura donc un rôle de prévention contre la maladie. De concert avec le médecin, s'il y en a un attaché au service et l'ingénieur sanitaire dans plusieurs endroits également, elle travaille donc au maintien de la santé des employés, facteur des plus importants en industrie où elle a valeur de rendement.

L'infirmière s'emploie ingénieusement par des affiches, la distribution de tracts concernant l'hygiène, par les entretiens qu'elle ménage aux employés, aux chefs de personnel, à la direction, à promouvoir un esprit sanitaire général et particulier. Guide précieux encore, elle enseigne à se prévaloir des services sociaux dont sont dotés la compagnie, la ville, et

la province où elle exerce. Car il ne faut pas que l'infirmière soit si absorbée par le nursing, qu'elle néglige pour autant les points de vue diététique, dentaire, puériculture, mental, pour n'en mentionner que quelques-uns.

Sur son terrain particulier, l'infirmière industrielle a peut-être plus de latitude que dans tout autre service du nursing. Mais en cela, et peut-être à cause de cela, elle se pique parfois d'une certaine indépendance et vit en marge des autres groupements de sa profession. Si elle se considérait plutôt comme un agent de relations extérieures entre celle-ci et le public qu'elle sert, elle y trouverait vite son compte, en interprétant l'idéal, l'enseignement, et les oeuvres à l'occasion, se tenant ainsi du même coup à la page.

En apprenant naguère à soigner les malades, l'infirmière a-t-elle été convaincue que l'étude de la santé avait aussi sa valeur intrinsèque? En connaissant cette santé et en la considérant comme un bien très précieux, on se sent disposé à la servir. En ce domaine, les moyens n'ont-ils pas trop souvent été laissés à la disposition des profanes? A l'infirmière industrielle revient en grande partie la tâche d'aller de l'avant en posant les jalons qui servent à charpenter le programme de santé dans une compagnie. Elle donne là son premier effort. Les traitements et les soins d'urgence deviennent ensuite des compléments du service de santé proprement dit. L'enseignement, combiné avec les soins donnés à domicile, offre encore dans certains milieux l'occasion d'un emploi économique du temps à qui est préposée à la garde de la santé des

Mlle Gauvin est infirmière à la Cie des Tramways de Montréal.

employés. Dans toutes les phases de ce travail, l'oeuvre éducatrice qu'elle fait tend à le réduire pour une autre fois. Par exemple: L'épouse à laquelle on aura enseigné à donner les soins nécessaires à son mari malade saura se débrouiller désormais et voilà autant de gagné pour le service.

Si l'infirmière a les connaissances nécessaires, un jugement sain, une stabilité personnelle, un accueil bienveillant, elle aura du succès, par exemple, dans les relations patronales en faisant bénéficier bien discrètement de son point de vue. Dans ses relations avec les patients, elle *donne* et elle *reçoit*. Elle donne un traitement, un renseignement et, durant ce temps, elle reçoit des confidences, les informations les plus variées sur le ski, la lecture, le jardinage, la couture, la construction, les voyages et que sais-je... Pour profiter de tout cela, elle doit faire preuve d'intérêt, d'un sens de l'humeur, de psychologie, d'instruction suffisante, de bonté réelle pour se faire toute à tous et sentir un courant de confiance générale qui s'établit. Les fils conducteurs à tout ce qui précède:

1. Le centre de santé accessible à tous.
2. Les soins d'urgence.
3. La collaboration avec le service de sûreté.
4. Les bonnes relations avec le département du personnel, du caféteria ou de la cantine, et avec les chefs de départements.
5. L'usage opportun des services sociaux extérieurs.
6. L'assistance dans l'élaboration des loisirs en groupe.

En septembre dernier, à Queen's, se tenait un institut durant trois jours. Avec les infirmières de 70 industries, je recueillis à cette université centenaire, les données actuelles de professeurs très compétents en médecine, en nursing, et en relations industrielles. Nos cours portaient sur le santé, la famille, les travailleurs, l'art de conseiller, les médicaments nouveaux, et les techniques récentes

pour pansements. L'impression m'est bien restée que "l'infirmière, pouvant prévenir la maladie, rend un plus grand service à son pays que celle qui peut seulement la guérir."

Ces renouveaux, que sont les instituts, les cours de revue, et les conférences traitant du nursing industriel, sont des plus utiles et appréciées. Ils aident entre autres avantages à consacrer officiellement le nursing industriel en fonction de l'hygiène publique, en s'imposant à l'attention des compagnies.

Nous avons pensé qu'une petite bibliographie à la suite de cet article serait propre à inspirer celles qui ont le temps d'approfondir les notions déjà acquises. Elle est en quelque sorte le complément obligé de l'exposé que nous venons de faire. Nous regrettons de n'en pouvoir mentionner une française, le sujet, à part de rares articles, n'ayant pas encore tenté la plume de nos hygiénistes. Voilà de quoi aiguïser notre appétit. Qui commencera?

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Nursing Profiles

Olive Frances Griffith has joined the faculty of the University of Toronto School of Nursing as a lecturer, with the special function of coordinating the teaching of psychiatric nursing. A graduate in 1933 from King's College Hospital, London, Eng., Miss Griffith completed her specialization in mental nursing at the Maudsley Hospital, London, in 1936 and became administrative sister at Claybury Hospital. A recipient of a Florence Nightingale International Foundation award from the National Council of Nurses of Great Britain, Miss Griffith secured her certificate in hospital administration and nursing education and her diploma in mental nursing from London University in 1938.

From 1942 to 1945, Miss Griffith was first assistant matron at the Mill Hill Emergency Hospital for the treatment of war neuroses. She went with UNRRA to Greece in 1946 as psychiatric nursing consultant. On her return to England she was appointed an inspector of training schools under the General Nursing Council of England and Wales. With her wide experience, her direct mind, her ability for critical consideration and immediate grasp of detail, Miss Griffith will have a valuable contribution to make to the progress of mental nursing and teaching.



OLIVE GRIFFITH

Since she was a small child, **Helen Ruth Durrant** has had the desire to go to the mission field. Born on a farm near Mitchell, Ont., she graduated in 1943 from the Stratford General Hospital. After doing some private

nursing she spent three months as a general duty nurse at Norfolk General Hospital, Simcoe, Ont., before joining the R.C.A.F. on May 2, 1945. After discharge from the service she took the operating-room technique and management course at St. Michael's Hospital, Toronto. She spent three years at Toronto Bible College before starting off for Brazil as a nurse missionary under the Evangelical Union of South America. There her nursing knowledge will be used as a means of approach to the spiritual welfare of the people in northern interior Brazil. She sailed in February. The first year will be spent in language study, after which she hopes to be able to start a dispensary.



HELEN DURRANT

Olive Waterman has come out of retirement to assume the duties of director of nursing at the Greater Niagara General Hospital, Niagara Falls, Ont. A graduate from Peterborough Civic Hospital, Miss Waterman has had considerable experience in both administration and teaching in Ontario, including an instructorship in St. Thomas, superintendent of Lady Minto Hospital, Cochrane, of the Soldiers' Memorial Hospital, Orillia, and more recently superintendent of nurses at the McKellar Hospital in Fort William.

History and biography form Miss Waterman's favorite reading material. She is fond

of good music and drama. She loves the out-of-doors. She was a charter member of the Soroptimist Club of Fort William and Port Arthur.

Rae Chittick has been awarded one of two scholarships from the Canadian School Health Research Association for a year's study at Harvard. She plans to undertake this work next fall. Miss Chittick has been assistant professor in the Faculty of Education, University of Alberta, Calgary, for many years. We rejoice in this recognition of the splendid contribution Miss Chittick has made to public health.



Falliday

RAE CHITTICK

Sister St. Joseph, who has made a signal success of her work as superior of the Hotel Dieu in Bathurst, N.B., since her appointment there, has been transferred to administer the new hospital of her order at Sorel, Que. A native of Gascons, Que., Sister St. Joseph entered the congregation in 1922 and received her training at Hotel Dieu, Camp-



ALENA MACMASTER

bellton. After serving there for ten years, she spent the next decade at the Vallée Lourdes Sanatorium in New Brunswick. She was appointed to organize the Bathurst Hospital in 1942. Along with all her other work, Sister St. Joseph has found time to take special training in dietetics. She also earned her B.Sc. in nursing from Sacred Heart University and a diploma in hospital administration from the Catholic Hospital Association. **Sister LaPlante**, former superintendent of the nursing school and head of the maternity floor, was appointed to succeed her as superior at Hotel Dieu, Bathurst.

Alena J. MacMaster has been appointed superintendent of nurses at the Soldiers' Memorial Hospital, Campbellton, N.B. Since she resigned in 1947 from the Moncton Hospital, where she had been superintendent for 28 years, Miss MacMaster has been working in the United States where she had earlier spent many years in professional posts. She is a charter fellow of the American College of Hospital Administrators.

Portrait is Unveiled

Tuesday evening, February 21, 1950, was a happy occasion for the Alumnae Association of the School of Nursing of the University of Toronto, when they presented to the

University an Archibald Barnes portrait of Miss Kathleen Russell, who has been director of the school for nearly 30 years.

The ceremony took place in the flower-

decked Common Rooms of the school at 7 Queen's Park and, despite a blizzard, a large group of Alumnae members and guests assembled to honor Miss Russell. Receiving the guests with Miss Edith Dick, Alumnae president, and Miss Russell, were Mrs. Sydney Smith and Mrs. J. S. D. Tory.

Dr. Sydney Smith, president of the University, presided and his opening words are worthy of repetition: "Miss Russell is an illustrious and outstanding member of the University staff. She is renowned at home and proclaimed abroad and is a brilliant exception to the statement that a prophet is not without honor save in his own country. The genius of educational structure is found in the calibre of its staff. Miss Russell has demonstrated to a unique degree a capacity for high talent, vision and energy, and she has laid those talents at the feet of those she has served.

"It is significant that Miss Russell is still in office. There are not many direct rewards of teaching but there are commensurate rewards—the high regard, esteem, and affection of the student. The tenth commandment forbids us to covet but it is not wrong for a teacher to covet the regard and esteem of the student. Miss Russell has never sought this honor and esteem but they have always been cordially extended to her. She has been a gifted expositor, a guide and a friend, and has always displayed qualities of vision and devotion. She is a scholar and a lady."

Miss Dick warmly welcomed the guests and expressed the delight and satisfaction of the Alumnae in having accomplished this project. Greetings were read from graduates from Venezuela, Belgium, and New Zealand as well as from our own country. Miss Dick spoke of our indebtedness to Miss Russell for her distinguished service as director of the school. It has grown steadily so that now there are six courses offered, including a basic undergraduate course leading to the degree of Bachelor of Science of Nursing. There are now over 2,000 graduates of the school who are actively engaged in nursing in 50 countries. Research has accompanied each phase of development and is carried on continuously. The guiding philosophy of the school has been and is the blending of the study of the humanities with a broad professional education.

Again and again Miss Russell has received outstanding recognition and brought signal honor to the school. It was with pride that



Photo by The Telegram, Toronto

Miss Russell and her portrait

Miss Dick referred to this great prestige. Dr. Raymond Fosdick, the former president of the Rockefeller Foundation, in his report of 1947, referred to the School of Nursing in these words: "Kathleen Russell's leadership, scholarly ability, and insight into the community's nursing needs have produced an outstanding research program and Toronto is one of the peaks of nursing training in the world."

Another representative of the Rockefeller Foundation, Dr. L. W. Hackett, the director of the International Health Division in South America, suggested that Miss Russell's influence goes beyond the scope of the nursing world. When speaking in Toronto a short time ago he said, "You would be surprised to know how the influence of this school and of Miss Russell, its director, has spread throughout South America. One of our basic programs in South America is the improvement of the education of nurses and a majority of the Latin-American girls, chosen to study abroad on our fellowships, have been sent to Toronto."

The Alumnae Association was happy to have Miss Florence Emory, honorary vice-president, unveil the portrait. Miss Emory expressed the hope that Miss Russell's sure hand would continue to guide the destiny of the school for many years to come.

In receiving the portrait, Miss Russell

expressed her deep appreciation and thanks to the Alumnae Association for their unfailing loyalty and kindness through the years. It was significant, she said, that the first Alumnae president, Mrs. H. J. Cody, and all her successors were present at the ceremony.

Mr. J. S. D. Tory accepted the portrait on behalf of the Board of Governors and, in so doing, expressed the pleasure of the

University in having the portrait as a memorial "to a lifetime of service given to the University, to this country, and to the world." Mr. Tory paid tribute to Miss Russell's persistence in always urging what she thinks best for the school.

Following the ceremony a social hour was spent and refreshments were served. Among the guests was the artist, Mr. Archibald Barnes.

In Memoriam

Ella May Chalue, who graduated with the class of 1902 from St. Michael's Hospital, Toronto, died at her home in Penetanguishene, Ont., on October 4, 1949. Miss Chalue had been in ailing health for some time.

* * *

Elva (Stevens) Ellis, who graduated from St. Paul's Hospital, Vancouver, in 1917, died in Chicago.

* * *

Ellen Gerard, who graduated from Grace Hospital, Detroit, in 1900, died in Windsor, Ont., on February 7, 1950, following a brief illness. She had engaged in private nursing until World War I broke out when she enlisted with the C.A.M.C. She served in France and Salonika until she was invalided out of service in 1916. Following her return home she was on the staff of Christie St. Hospital, Toronto, for some time before becoming a school nurse in Windsor.

* * *

Mary Gleason, an early graduate of the General Hospital, Sault Ste. Marie, Ont., died on January 24, 1950. Miss Gleason was night supervisor at the Niagara Falls General Hospital for many years before becoming

industrial nurse with the Kimberley Clarke Co. of Niagara Falls. Last October she was feted as a tribute to her 25 years' service with that firm.

* * *

Laura Sime, who graduated from the Toronto General Hospital in 1922, died in Saint John, N.B., on October 7, 1949.

* * *

Jean (Aikenhead) Sinclair, a graduate of the Misericordia Hospital, Winnipeg, died in Winnipeg on January 16, 1950.

* * *

Lily Smiley, a graduate of the Montreal Woman's Hospital in 1902, died at her home in Warden, Que., on August 5, 1949. Miss Smiley had been retired and in failing health for some time.

* * *

Leola Watson, who graduated from the Vancouver General Hospital in 1930, died at her home in Lethbridge, Alta., on January 31, 1950, after an illness of only two weeks. Since 1937, Miss Watson had been with a medical firm in Lethbridge.

Regarding our Official Directory

Four times a year—March, June, September, and December—the officers, etc., of many associations are listed in our Official Directory. Please check your list as it appeared in March and let us have any corrections before *May 1* in preparation for the June issue.

Trends in Nursing

Average reading time — 6 min. 48 sec.

General Secretary Reports on Newfoundland

FOLLOWING AN INVITATION extended by the Newfoundland Graduate Nurses' Association to visit Newfoundland and to discuss their nursing organization with a view to making recommendations which could be considered in future plans, the general secretary of the C. N. A. left by plane for St. John's on February 1. From the time of her arrival until her departure 12 days later she was occupied in meeting various people concerned with the health, welfare, and education of the people of Newfoundland, and in studying the nursing situation in relation to their needs.

Despite the fact that since Confederation there has been an almost continuous flow of visitors—official and otherwise—the directors of health and hospital services greet each newcomer with a friendly enthusiasm and kindness, and courtesy is extended by everyone. Apart from numerous official interviews and conferences arranged on her behalf by the Deputy Minister of Health and the officers of the Newfoundland Graduate Nurses' Association, the general secretary was privileged to visit some of the outpost cottage hospitals and to study at first-hand the fine work being done by the medical and nursing staffs in these centres. Dr. James McGrath, assistant director of Medical Services, Newfoundland Department of Health, neatly described the situation as follows:

Health services in Newfoundland have their own peculiar problems, not the least of which is geography. There are more than 1,500 settlements scattered over a coast-line so long and indented that it has never been accurately estimated but which the more conservative assessments consider to be 6,000 miles in length. Distance, isolation, and thinness of population, together with lack of trans-

portation facilities, all contribute to the difficulties of getting service to the individual in time of need.

In spite of this, a surprisingly large proportion of the population is within easy reach of acceptable emergency and hospital service, but in many areas domiciliary medical service is available only with great difficulty. There are some 14 districts outside the capital, organized on a contributory fee basis and centred on cottage hospitals. It is proposed to extend this service to other districts in the near future. There are 52 part-time medical health officers and 25 full-time district nurses. There are: (a) 19 nursing districts; (b) 5 nursing stations; (c) 14 cottage hospitals; (d) the St. John's Unit.

The contributory cottage hospital scheme is the backbone of the medical service to the outlying population. The head of each household pays an annual fee of \$10. For this he and all dependent members of his family receive all necessary medical services, including hospitalization. If there are other adults in the family earning independent incomes, they pay a personal fee of \$5.00 per year. If a patient has a serious condition beyond the scope of the cottage hospital facilities, he will be admitted to a larger hospital in St. John's without charge, and patients have been sent as far as Montreal for brain surgery under this scheme.

Visitors cannot help but be impressed by the development of the health program in Newfoundland. The officials of the Department of Health are meeting courageously what might well be described as a herculean task in providing services, preventive and curative, to a population so widely dispersed and in a country which, due to seasonal and transportation difficulties, is frequently inaccessible.

It was gratifying indeed to the

general secretary to address such large groups of nurses, both in St. John's and Corner Brook, and to find such enthusiastic response to the suggestions put forth for the change of nursing organization which will be necessary in order to become a provincial registered nurses' association.

It is confidently expected that the nurses of Newfoundland will very soon be prepared to affiliate with and to share in the work of the Canadian Nurses' Association. Meantime, it is hoped that many of their members will find the ways and means to attend and participate at the biennial convention in June.

Have You Heard?

We wish you could have been a fly on our shoulder and could have listened in with us when we represented the Canadian Nurses' Association at a most interesting meeting on Adult Education, when the Joint Planning Commission of the Canadian Association of Adult Education convened in Montreal. The member organizations now number 86, 65 of which are distinctly national in character, with the remaining 21 belonging to the university or adult education field.

The feature of this meeting seems of especial interest to nurses at this time, preparing as they are for the ten work conferences to be held at our coming biennial in June. The highlight of the meeting was the subject—Implications of Group Dynamics for Adult Education—which was discussed by Dr. Leland Bradford, director of the Adult Education Division of the National Education Association in Washington, and also director of the National Training Laboratory in Group Development held each summer at Bethel.

Dr. Bradford explained what is meant by *Group Dynamics*—that it is primarily an area of study, inquiry, and research in the process of which groups work, discuss, reach a decision, plan action, and carry it into effect. In any human situation the action which occurs is determined by a set

of forces—many or few—which are present in the field of the moment and these forces are themselves in the process of change.

One of the forces most effective in the group is the leader and the effect of her leadership. It is the leader's responsibility to see that the group develops in democratic thought and action. This is done by giving suggestions to the group rather than making decisions, and by helping the group to take responsibility for themselves, instead of assuming responsibility for the group. In point of fact, the more a leader has to give, the more imperative it is that she should be freed as leader and become part of the group.

Other effective forces in the group are the "observer" and "recorder." The observer points up the weaknesses, and her attitude to the group must be such that it does not give rise to conflicts between herself and members of the group or between one member and another. Much depends upon her sensitivity to what happens in the group and her methods of reporting the "how" and "why" of success or failure in reaching a decision.

From the recorder or secretary can be found those areas where improvements can be made by experimenting and evaluating results in a scientific way. Observation scales have proved to be of value.

In the final analysis, the most effective force in the group is each individual member, the human relations within the group, the words that are spoken and the thoughts that remain unsaid—all color the final decision. The group acts out its program and analyzes itself as it goes along, that it may grow in efficiency and achieve greater productivity, for the growth of a group lies in itself.

At least a day for leadership training is advised, as well as training for observers and recorders, before any series of conferences or committee meetings. Knowing the value of this, the Canadian Nurses' Association has planned for such a day, previous to the conferences to be held at the biennial.

A full day will be devoted to the instruction of leaders, observers, and recorders or secretaries.

Important Pamphlets

Two interesting pamphlets have recently reached our desk. The one entitled "The United Nations and Adult Education" which briefly outlines what we, the run-of-the-mill people, must do in order that the United Nations can achieve its purposes, discusses adult education and how adult groups may learn about the United Nations. It lists source material in the form of publications, charts, films, filmstrips, radio, and contains

other valuable information. *Price in U.S.A., 15 cts.—Sales No. 1949-1-18.* The other, entitled "Our Rights as Human Beings," is a discussion guide on the Universal Declaration of Human Rights. How many nursing groups have discussed the Declaration of Human Rights? If nurses are not discussing this Declaration is it due to lack of interest, to inertia, to ignorance? If you are forming a discussion group, this pamphlet would be extremely helpful. *Price 10 cts.—Sales No. 1949-1-21.* Both pamphlets are United Nations publications and may be purchased through *United Nations Sales Agent, The Ryerson Press, 299 Queen St. W., Toronto 2B.*

Orientation et Tendances en Nursing

VISITE DE LA SECRÉTAIRE NATIONALE À TERRENEUVE

En réponse à une invitation faite par l'Association des Infirmières Graduées de Terre-neuve, Gertrude M. Hall, la secrétaire nationale, leur rendit visite dans le but de connaître cette association et faire des recommandations pour l'admission de cette province dans la fédération nationale de l'Association des Infirmières du Canada.

Avant son départ, Mlle Hall fit une étude approfondie de la situation à Terre-neuve. Après avoir conféré avec diverses personnes et avoir lu de nombreux rapports et volumes, Mlle Hall était familière avec les conditions de santé, de bien-être, et d'éducation à Terre-neuve. Depuis l'entrée de Terre-neuve dans la Confédération, le flot des visiteurs a été ininterrompu, visites officielles et autres; néanmoins les nouveaux venus sont encore accueillis avec bonté et courtoisie par tous.

Après plusieurs entrevues arrangées par le Sous-Ministre de la Santé et le Comité de Régie de l'Association des Infirmières Graduées de Terre-neuve, la secrétaire fut invitée à visiter les hôpitaux d'avant-poste et put étudier le bon travail accompli par les médecins et les infirmières dans ces endroits isolés.

Le Dr James McGrath, assistant-directeur des services médicaux, décrit ainsi la situation

à Terre-neuve: "Les services de santé à Terre-neuve présentent des problèmes particuliers—l'un des plus importants est de nature géographique. Il y a plus de 1,500 établissements éparpillés sur une longueur de côte que personne encore n'a pu déterminer d'une façon précise, mais que les plus conservateurs estiment de 6,000 milles de longueur. Il est difficile de donner des soins à une personne lorsqu'elle en a besoin à cause de la distance." Malgré tout, il est surprenant de constater qu'une grande partie de la population peut avoir accès assez facilement aux hôpitaux et recevoir des services en cas d'urgence, mais par contre dans certaines régions il est extrêmement difficile d'obtenir des soins en maladie.

En dehors de la capitale, il y a 14 hôpitaux ruraux contenant environ de 15 à 50 lits (cottage hospital). Les infirmières visiteuses ont mission de donner des soins et d'enseigner la santé dans les cinq avant-postes. Vingt-cinq infirmières, attachées à des districts, correspondent un peu à nos unités sanitaires dans une région beaucoup plus isolée toutefois et 52 officiers médicaux sont employés à temps partiel.

Une forme d'assurance en maladie volontaire est payée aux hôpitaux ruraux par 14 districts. Le chef de famille paie \$10 par année. Pour cette somme lui et les membres

de sa famille sont assurés de recevoir les soins médicaux et l'hospitalisation. Si un membre adulte de la famille gagne un salaire, il paye en plus \$5.00 par année. Si le malade, à cause de son état, a besoin d'être admis dans un plus grand hôpital, il est hospitalisé à St-Jean, sans frais additionnels. Il y a même des malades qui ont été envoyés à Montréal pour des opérations sur le cerveau.

Tous les visiteurs sont impressionnés par le développement des services de santé à Terre-neuve. Le Ministère de la Santé se met courageusement à cette tâche herculéenne qui l'attend, étendre la médecine préventive et curative à toute une population clairsemée sur une si vaste étendue, dans un pays où les saisons et le transport difficile rendent souvent les voyages impraticables.

C'est avec une grande satisfaction que notre secrétaire adressa la parole aux infirmières réunies à St-Jean et à Corner Brook. L'on répondit avec enthousiasme aux suggestions faites, aux changements nécessaires à apporter à l'association actuelle.

Nous pouvons déjà dire que l'Association des Infirmières Graduées de Terre-neuve sera bientôt prête à être affiliée à l'Association des Infirmières du Canada et nous espérons que plusieurs de leurs membres pourront assister au congrès biennal en juin prochain.

ETES-VOUS AU COURANT?

A la séance conjointe de l'Association d'Education des Adultes (section anglaise) et de l'A.I.C., le Dr Leland Bradford discuta du "Dynamisme de Groupe"—il expliqua ce que l'on entendait par ce terme. C'est une étude sur un sujet déterminé, enquête, recherche par un groupe. A la suite de discussion, un plan d'action est déterminé et mis en pratique. Toute action chez les humains est la manifestation d'une énergie présente au moment de l'action et se transformant.

Dans un groupe, l'énergie la plus efficace est celle du chef de groupe et elle se manifeste dans sa conduite du groupe. Le chef du groupe doit se rendre compte d'une façon démocratique si chacun des membres du groupe

développe sa pensée et son plan d'action. Pour arriver à cette fin, le chef de groupe fera des suggestions plutôt que de prendre des décisions. Il aidera le groupe à assumer ses responsabilités. Un chef de groupe qui a beaucoup à donner doit plutôt participer aux discussions du groupe que de les diriger.

Une autre source d'énergie est l'observateur et le secrétaire du groupe. L'observateur fait remarquer les points faibles. Son attitude envers le groupe ne doit pas déterminer de frictions entre elle et le groupe, ni entre un membre et un autre du groupe.

En lisant le rapport de la secrétaire, plusieurs améliorations peuvent être faites et l'on peut évaluer les résultats obtenus. En dernier lieu, la source d'énergie la plus importante est chaque personne formant le groupe—les idées que l'on a exprimées et celles que l'on n'a pas osées dire auront un effet sur la décision finale. Le groupe, tout en poursuivant le travail qu'il s'est assigné, s'analyse durant ce temps et chaque membre devient plus efficace, promet de donner un meilleur rendement, et se développe individuellement à mesure que le groupe avance.

Lors du congrès biennal, l'A.I.C. se propose de conduire les foyers d'étude selon les directives données par le Dr Langford. Une journée d'étude, à laquelle tous les chefs de groupes seront conviés, sera donnée afin d'initier les chefs à leurs devoirs envers les groupes.

UNE PUBLICATION IMPORTANTE

Un intéressant opuscule vient d'être publié, intitulé "Les Nations Unies et l'Education des Adultes," dans lequel l'on montre ce que l'homme ordinaire, l'homme moyen, peut faire pour que les Nations Unies puissent atteindre le but qu'elles se sont proposé et comment, par l'éducation des adultes, l'on peut renseigner des groupes sur les Nations Unies. Une liste des publications, des films, des films éclairés, et des programmes radiophoniques constitue une source d'information très utile. Ecrivez à: *United Nations Sales Agent, The Ryerson Press, 299 Queen St. W., Toronto 2B, Ont.*

50th Anniversary Dinner

Attention! Calling all Graduates of *Civic and former Nicholls Hospital, Peterborough, Ont.* The 50th Anniversary Dinner will be held on *May 5* at the Empress Hotel. For reservations notify *Jean Gillespie, 275 Thomas St., Peterborough.*



At last the cold and snow of winter and the harsh March winds are gone and we are in the middle of April—that lovely month with its soft murmurings of growing things and promise of summer days. What better way to renew our spiritual and physical vigor than by attending the biennial meeting, viewing new scenes, renewing old friendships and, mayhap, parting with a few old prejudices?

GENERAL INTEREST SESSIONS

Would you like to see and hear about something which is close to the heart of every nurse—yes? We mean just plain nursing, the kind of nursing care being given to patients today on the medical and surgical wards in our general hospitals; the eye, ear, nose and throat department; the obstetrical and gynecological departments; the children's ward; the communicable disease and tuberculosis divisions; the neurological wing; the paraplegic ward; the psychiatric section.

We thought you would. We have yet to meet a nurse who does not become keenly interested, either in telling or hearing about new methods of procedures or new treatments for patients. For this very reason the Program Committee for the biennial meeting has asked the chairman of the Institutional, Private Duty, and Public Health Nursing Committees to work together in the preparation of demonstrations in each of the specialties. This part of the program is known as "General Interest Sessions." These sessions are scheduled for the afternoons of Tuesday, June 27, through to Thursday, June 29, from 2:00-5:00 p.m. and for Tuesday evening, June 27, from 7:00-8:00 p.m. One or more large rooms will be used for the purpose and will be curtained off, so that

each specialty will have its own "special" spot. Skilled nurses will carry out the demonstrations and explain the use of special or new equipment, and we have just learned that the Neurological Institute in Montreal has planned for a nurse and doctor to collaborate in the demonstrations of their procedures.

The demonstrations and exhibits connected with public health and visiting nurses promise to be extremely interesting and valuable. From this variety it should be possible to satisfy the needs and desires of every member attending the convention. At least that is our objective. Plan now to include the biennial convention of the Canadian Nurses' Association on your calendar for June, 1950.

WORK CONFERENCES

We have something more to say about Work Conferences. The following outlines will enable you to become increasingly aware of the variety of the program and of the opportunities afforded to work with specialists in each particular area.

JOB ANALYSIS OF NURSING SERVICES

Consultants: **Mr. B. H. Peterson**, personnel director, City of Vancouver, B.C.; **Mr. K. R. Martin**, personnel consultant, Hospital Insurance Service, Victoria, B.C.; **Trenna Hunter**, director of Public Health Nursing, Vancouver, B.C.; **Elva Honey**, area nursing consultant, Treatment Services, D.V.A., Montreal.

General aim: To analyze the work of the professional nurse and of auxiliary personnel in order to determine the nature of the services that should be rendered by each group.

Work conference purposes:

1. To discuss the major purposes of job evaluation.
2. To discover why there is a need to analyze the various jobs in nursing.
3. To consider methods used in evaluating the work of nursing personnel.
4. To consider how analysis and evaluation will clarify functions.

Sub-topics:

1. Job description.
2. Evaluation of work.
3. Evaluation of performance.
4. Determination of salary rates.

METHODS OF EVALUATING STUDENT PROGRESS

Consultants: **Helen Penhale**, professor and director of the school, University of Alberta Hospital; **Sister Jeanne Forest**, instructor in Nursing Education, Institut Marguerite d'Youville; **Frances McQuarrie**, supervisor of instruction, University of Alberta School of Nursing.

General objectives: To afford an opportunity for group participation in the study of methods of appraising the nurse's growth in ability to give a high quality of nursing care and the development of personal qualities which are characteristic of an effective nurse.

Work conference purposes:

1. To discuss why students' progress is evaluated.
2. To consider ways and means of learning how effective we are as teachers.
3. To consider how we may learn whether students are growing in knowledge and skill.
4. To discuss ways and means of learning whether students are developing desirable attitudes, interests, ideals, and appreciations.

Overview: Through better means of evaluating student achievement will come an improvement in the education and hence the graduation of better nurses.

The student's progress must be thought of in terms of her ability to acquire functional knowledge, habits of conduct and useful skills, the development of attitudes, interests, ideals, and appreciations.

An appropriate plan for evaluating student progress seems to be to pre-

sent evaluation in the three major fields—the basic sciences, nursing arts, and in the clinical areas. To be effective the educational program will have brought about certain desired changes in the behavior of the student. These behaviors include particularly attitudes and interests. Since all nurses are concerned with the development of these outcomes, a general conference will be conducted on the development and appraisal of desirable personality characteristics, interests, attitudes, and ideals.

Sub-topics:

1. EVALUATION OF STUDENT'S PROGRESS IN THE BASIC SCIENCES.

The basic sciences are included to give a background of factual information upon which to build good nursing care. They develop within the student the ability to observe, state facts, and draw conclusions, as well as to distinguish scientific information from that of superstition and quackery. How are we as instructors to appraise the effectiveness of our teaching and the students' learning in the development of these outcomes?

2. EVALUATION OF STUDENT'S PROGRESS IN THE NURSING ARTS.

The desired outcomes in nursing arts include the student's grasp of essential knowledge, her ability to give satisfactory nursing care, her understanding of health and hygiene principles and, above all, the soundness of her learning in relation to the welfare of her patients. Who is in the best position to evaluate students' progress in skill? How can this person do this adequately?

3. EVALUATION OF STUDENT'S PROGRESS IN THE CLINICAL SERVICES.

In the clinical areas, the student has an opportunity to apply the knowledge and principles she has gained from the biological, physical and social sciences, and from nursing and the allied arts. Does her nursing performance indicate an application of the knowledge gained in the above courses and an ability to adjust to new and changing situations?

THE NURSING TEAM

Consultants: **Lorna Horwood**, assistant professor of nursing, University of British Columbia; **Miss J.**

F. Ferguson, registrar-consultant, School of Nursing Aides, Calgary; **Esther Robertson**, western supervisor, Victorian Order of Nurses; **Marjorie Russell**, director of nursing, Phillips Training School, Montreal; **Mrs. L. H. Fisher**, director, Montreal School for Nursing Aides.

General objective: To acquaint nurses in hospital and other community health fields with the current trends towards team-work in nursing in order to develop interest that may stimulate a desire for wider knowledge and understanding, promote the application of the principles of team-work in the practical situation, and lead to experimentation in the various fields of nursing.

Work conference purposes:

To provide opportunity for a study of the services rendered the patient by many groups of workers whether in home or hospital and how to use these services in the best interest of the patient, the institution, and the worker.

Sub-topics:

1. The need of a variety of workers to serve the patient and how to organize these workers into nursing teams.

2. A study of the functions of (a) the professional nurse and (b) the auxiliary worker.

3. Consideration of methods that will help nurses to function as teachers and team leaders in hospitals.

4. Team-work between hospitals and other community agencies.

Nomination Ticket, 1950-52

The following is the Nomination Ticket, 1950-52, for the officers, chairmen, regional representatives of the nursing sisterhoods, and Nominating Committee of the Canadian Nurses' Association. The names are listed in alphabetical order, where multiple nominations occur. The present position of each nominee is indicated:

President: Miss Eileen C. Flanagan, nursing supervisor, Neurological Institute, Montreal, Que.; Miss Helen G. McArthur, national director of nursing services, Canadian Red Cross Society, Toronto, Ont.

First Vice-President: Miss E. A. Electa MacLennan, director, Dalhousie University School of Nursing, Halifax, N.S.; Miss Gladys Sharpe, director of nursing, Western Hospital, Toronto, Ont.

Second Vice-President: Miss Trenna G. Hunter, director of nursing, Metropolitan Health Committee, Vancouver, B.C.; Miss M. Christine Livingston, chief superintendent, Victorian Order of Nurses, Ottawa, Ont.

Third Vice-President: Miss Katharine MacLennan, superintendent of nurses, Provincial Sanatorium, Charlottetown, P.E.I.; Miss Bertha Pullen, director of nursing, General Hospital, Winnipeg, Man.

Chairman, Institutional Nursing Committee: Miss Muriel Graham, director of nursing

education, Children's Hospital, Halifax, N.S.; Miss Vera Graham, director of nursing, Sherbrooke Hospital, Que.; Miss Mary E. Macfarland, director of nursing, General Hospital, Toronto, Ont.; Miss Lucy Rechenmacher, St. Paul's Hospital, Saskatoon, Sask.; Miss Annie Thomson, director of nursing, Civic Hospital, Peterborough, Ont.

Chairman, Private Duty Nursing Committee: Mrs. Eva Brackenridge, Peterborough, Ont.; Miss Norene Malone, Sherbrooke, Que.

Chairman, Public Health Nursing Committee: Miss Helen Carpenter, instructor, University of Toronto School of Nursing, Toronto, Ont.; Miss Jean Forbes, district superintendent, Victorian Order of Nurses, Halifax, N.S.; Miss Margaret E. Hart, director, University of Manitoba School of Nursing, Winnipeg, Man.; Miss Annonciade Martineau, supervisor with the Department of Health, Montreal, Que.

Regional Representatives of the Nursing Sisterhoods:

Maritimes: Sister Catherine Gerard, associate administrator, Halifax Infirmary, N.S.

Quebec: Sister Denise Lefebvre, director of nursing, Institut Marguerite d'Youville, Montreal, Que.

Ontario: Sister Mary Grace, director of nursing, St. Mary's Hospital, Kitchener,

Ont.; Sister St. Oswald, Hotel Dieu, Kingston, Ont.

Manitoba—Saskatchewan: Sister Delia Clermont, director of nursing, St. Boniface Hospital, Man.

Alberta—British Columbia: Sister Mary Claire, director of nursing, St. Joseph's Hospital, Victoria, B.C.

Nominating Committee: (Three to be elected); Miss Barbara Beattie, director of

nursing, Moncton Hospital, N.B.; Miss Rae Chittick, assistant professor, University of Alberta, Calgary, Alta.; Miss Winnifred Cooke, director of nursing, General and Marine Hospital, Owen Sound, Ont.; Miss Ethel James, instructor, General Hospital, Regina, Sask.; Miss Jean Masten, director of nursing, Hospital for Sick Children, Toronto, Ont.; Miss Edith Young, director of nursing, Civic Hospital, Ottawa, Ont.

C.N.A. Convention Bulletin of Information

Accommodation: All requests for accommodation on the campus should be addressed to *The Extension Dept., University of British Columbia, Vancouver*, on card provided for the purpose. These cards may be secured from your provincial Registrar. Since there are very few single rooms, persons who wish to room together are asked to make such requests when reserving accommodation. Arrangements have been made for the accommodation of the Nursing Sisterhoods.

Registration: Registration for the convention should be made on the triplicate forms provided for the purpose. Retain one copy and return the other two copies, together with the registration fee by bank or postal money order, to: *Canadian Nurses' Association, Suite 401, 1411 Crescent St., Montreal 25*. Acknowledgement of registration should be presented at the Registration Desk, *Saturday, June 24, from 9:00-12:00*

noon or Monday, June 26, from 9:00-5:00 p.m. The Main Housing Registration Desk is located in the Extension Department Office, Hut L-10, University Campus. A branch office is located at each camp. Consult reverse side of registration form for further particulars.

Meetings: Executive Meetings (place to be announced later); General Meetings in the Auditorium; Work Conferences in the Physics Building and adjoining huts; General Interest Sessions in huts—vicinity of the Physics Building.

Exhibits: All exhibits, including commercial, educational, *The Canadian Nurse*, etc., will be displayed on the first floor of the Physics Building and in the Exhibit Hut nearby.

Lippincott Lounge: Tea will be served at 4:15 each day in the Lippincott Lounge (place to be announced later).

Tentative Program of C.N.A. 25th General Meeting, Vancouver

Executive Meetings

*Thursday, June 22, Friday, June 23, and Saturday, June 24—*from 9:00-12:00 and 2:00-5:00. 7:00—Dinner for members of the Executive Committee. Guests of the Council, Registered Nurses' Association of British Columbia.

Registration

*Saturday, June 24—*9:00-12:00 noon.
*Monday, June 26—*9:00-12:00 noon; 2:00-5:00.

Monday—June 26

GENERAL SESSION, 9:00 A.M.

Place: The Auditorium.

Invocation: Rev. W. S. Taylor, M.A., B.D., Ph.D., Principal, Union Theological College, Vancouver.

Address of Welcome: The Hon. G. S. Pearson, Minister of Health and Welfare, B.C.

Greetings: Mr. C. E. Thompson, Mayor, Vancouver. Dr. Norman A. M. MacKenzie, president, University of British Columbia.

Dr. J. C. Thomas, president, B.C. Medical Association. Sister Columkille, president, Registered Nurses' Association of B.C.

Response to Address of Welcome: Miss E. M. Cryderman, president, Canadian Nurses' Association. Roll Call of Federated Associations. Presidential Address, Miss E. M. Cryderman. *Reports:* Secretary-Treasurer, Miss G. M. Hall; Finance Committee, Miss M. Myers; *The Canadian Nurse*, Miss M. E. Kerr; The Editorial Board, Miss M. S. Mathewson; Committee on Arrangements, Mrs. A. Wyness.

AFTERNOON SESSION

Reports—2:00-3:00 p.m.: Provincial Associations, President or Secretary of each provincial association. Committee on Institutional Nursing, Miss E. M. Palliser; Committee on Private Duty Nursing, Miss B. Key; Committee on Public Health Nursing, Miss T. G. Hunter; Committee on Health Insurance, Miss F. H. M. Emory; Committee on Student Nurse Activities, Miss M. E. Kerr.

Forum, 3:45-5:15 p.m.—The Impact of Health Service Plans on Nursing. Chairman, Miss Rae Chittick.

EVENING SESSION

Reception, 9:00 p.m.—Guests of Vancouver Alumnae groups.

Tuesday—June 27

Reports—9:00 a.m.: Educational Policy Committee, Miss A. J. Macleod; Metropolitan School of Nursing, Miss N. D. Fidler; Nominating Committee, Miss M. E. Kerr.

Panel, 10:45-12:00 noon—The Baby is Two. Chairman, Miss A. J. Macleod.

AFTERNOON SESSION, 2:00-5:00 P.M.

Work Conferences. General Interest Sessions.

EVENING SESSION

General Interest Session—7:00-8:00 p.m. General Meeting — 8:30-9:30 p.m. *Guest Speaker:* Dr. Martin Cherkasky, Home Care Executive, Montefiore Hospital, New York. *Topic:* A Program for the Care of Persons with Chronic Illness.

Social Hour: Brock Hall—9:30-10:30 p.m. Sponsored by the Greater Vancouver District, R.N.A.B.C.

Wednesday—June 28

Reports—9:00-10:00 a.m.: Committee on

Constitution, By-Laws and Legislation, Miss N. D. Fidler; War Memorial Committee, Miss M. E. Kerr; Loan and Bursary Committee, Mrs. C. Townsend; Canadian Florence Nightingale Memorial Committee, Miss E. K. Russell; Annuity Committee.

Labor Relations Forum, 10:00-11:00 a.m.—Miss Ina Broadfoot, Chairman.

Public Relations Committee, Miss H. G. McArthur; Exchange of Nurses Committee, Miss N. Mackenzie.

AFTERNOON SESSION, 2:00-5:00 P.M.

Work Conferences. General Interest Sessions.

EVENING SESSION

Banquet—7:00 p.m. Mary Agnes Snively Memorial Lecture. *Guest Speaker:* Dr. Charlotte Whitton, C.B.E. *Topic:* Trumpet in the Dust.

Thursday—June 29

GENERAL MEETINGS (CONCURRENT)

9:00-12:00 NOON

Sponsored by Committees on Institutional Nursing, Private Duty Nursing, and Public Health Nursing.

Luncheon Meeting—National and Provincial Secretaries. Guests of Council, R.N.A.B.C.

AFTERNOON SESSION, 2:00-5:00 P.M.

Work Conferences. General Interest Sessions.

EVENING SESSION, 6:00-10:00 P.M.

Cruise of the Harbor

Friday—June 30

9:00-12:00 NOON

Unfinished Business. New Business. *Speaker:* To be announced—10:30 a.m.

AFTERNOON SESSION

Summary of Work Conferences: Dr. M. Cherkasky, Miss D. Percy, Dr. W. G. Black, Miss M. Palk, Miss L. Horwood, Mr. B. H. Peterson, Miss M. E. Kerr, Mlle S. Giroux, Sr. Denise Lefebvre, Miss H. Penhale.

Report of Resolutions Committee. Scrutineers' Report. Election and Installation of Officers.

EVENING SESSION

Dinner—Overseas Nursing Sisters' Association.

Monday—July 3

Executive Meetings—9:00-12:00 noon; 2:00-5:30 p.m.

C.N.A. General Meeting Work Conferences

June 27, 28 and 29—2:00-5:00 p.m.

I	II	III
EVALUATION AND ACCREDITATION OF SCHOOLS OF NURSING <i>Consultants</i> , Sr. Denise LeFebvre, Institut Marguerite d'Youville, Montreal. Miss M. Street, Miss A. Macleod, Miss D. Riddell, Sr. Mary Claire.	JOB ANALYSIS OF NURSING POSITIONS <i>Consultants</i> , Mr. B. H. Peterson, Personnel Director, City of Vancouver. Mr. K. R. Martin, Miss E. Honey, Miss T. G. Hunter.	MEETING THE TOTAL NEEDS OF LONG-TERM PATIENTS <i>Consultants</i> , Dr. Martin Cherkasky, Home Care Executive, Montefiore Hospital, New York. Miss C. Livingston, Miss P. Morrison, Miss H. Sutherland, Mrs. E. Pringle, Miss A. Gage.
IV	V	VI
METHODS OF EVALUATING STUDENT PROGRESS <i>Consultants</i> , Miss Helen Penhale, School of Nursing, University of Alberta, Edmonton. Sr. Jeanne Forest, Miss F. U. McQuarrie.	COUNSELLING AND GUIDANCE <i>Consultants</i> , Dr. W. G. Black, Counsellor, Dept. of Psychology, Univ. of B.C., Vancouver. Miss M. Johnson, Miss J. Whiteford.	STAFF EDUCATION <i>Consultants</i> , Miss May Palk, Educational Director, Toronto Branch, V.O.N. Miss G. Sharpe, Miss E. Cryderman, Miss H. Carpenter.
VII	VIII	IX
THE NURSING TEAM <i>Consultants</i> , Miss Lorna Horwood, Dept. of Nursing, Univ. of B.C., Vancouver. Miss E. Robertson, Miss J. F. Ferguson, Mrs. L. H. Fisher, Miss M. Russell.	THE NURSE IN INDUSTRY <i>Consultants</i> , Miss Dorothy M. Percy, Civil Service Health Div., Dept. Nat. Health & Welfare, Ottawa. Miss S. A. Wallace, Miss M. I. Walker, Miss L. Miller, Miss G. Hyndman, Miss A. Palmquist.	LE TRAVAIL D'EQUIPE EN NURSING (French members) <i>Consultants</i> , Mlle Suzanne Giroux, Official Visitor of French Schools of Nursing, A.N.P.Q., Montreal. Miss A. Girard, Sr. Valérie de la Sagesse, Miss T. Gagnon.

X

STUDENT WORK CONFERENCE

Consultant, Miss Margaret E. Kerr, Editor and Business Manager, *The Canadian Nurse*, Montreal. Mrs. Lenora Kelly, Sister M. Felicitas.

C.N.A. GENERAL INTEREST SESSIONS

June 27, 28, and 29—2:00-5:00 p.m.

Both under-nourishment and over-nourishment present problems in clinical medicine. Gross under-nourishment results in amenorrhea, menstrual disorders, and a fall in con-

ception rate. Over-nourishment and sterility are commonly associated with infertility in women.

—Nutritional Observatory



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MODES OF ISSUE

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one (72%) were completely re-
lieved within 3 hours after treat-
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no relief." (1)

GRAVOL IN MOTION SICKNESS

98.6% effective in prevention of
sea sickness . . . eliminates symp-
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already developed. (2)

GRAVOL IN RADIATION SICKNESS

Out of 82 patients with moderate
to severe radiation sickness, 65
reported good to excellent relief.
(3)

FORMULA OF GRAVOL: Each
scored tablet contains: Beta di-
methylaminoethyl benzohydryl
ether 8-chlorotheophyllinate. . . .
50 mg.

PACKAGE: Available in vials of
25 and 100 scored 50 mg. tablets.

NOTE:—To date there is no evidence of toxic reactions with
Gravol. However, some individuals may become drowsy or
confused on high or continuous dosage.

References:

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VOLUME 46
NUMBER 5
MONTREAL
MAY
1950



THE CANADIAN NURSE

C.N.A. BIENNIAL
CONVENTION

June 26-30

Vancouver, B.C.

CONVENTION
REPORTS

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Nurses were among the first to discover Noxzema Skin Cream for skin comfort — new skin beauty!

LOOK LOVELIER IN 10 DAYS or your money back*

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—Everybody expects a nurse to look fresh, attractive, lovely at all times. But the hard, nerve-racking work, unusual hours play hob with a nurse's complexion. Most nurses occasionally have some little skin problems.

But now a skin specialist has developed a new beauty routine that actually helped 4 out of 5 women look lovelier—in just 10 days. Using Noxzema *medicated* Skin Cream, they were thrilled to discover remarkable improvement in their skin. Here's what they did:

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FOR YOUR PATIENTS' COMFORT

Try Noxzema Skin Cream to help heal the sore irritation of patients' sheet burns. They'll appreciate the delightful soothing relief they get from Noxzema's *medicated* formula. And here's a *new idea* in skin comfort they'll love! Use this dainty greaseless cream as a refreshing body massage. It's a wonderful skin tonic—will make them feel good *all over*! Noxzema is greaseless—so there's no worry about staining bed linen. Start using Noxzema *today*.



The woman who runs a home, cooks the meals, does the shopping, and keeps the small fry under control has to be made of stern stuff. Few men have what it takes to cope with the unceasing demands of a properly functioning household.

Even the "iron woman" may wilt after a day's work and when she does, the hidden cause may be that she has not enough iron in her blood. Anemia is very common in women because of periodic iron losses through menstruation, which range from 10 to 45 milligrams per period. Nutritionists at Cornell University recently estimated that, to hold her own, a woman must derive at least 10 to 11 milligrams of iron from her diet. Such a diet is not so easily provided. When iron deficiency anemia saps a woman's strength and strains her nervous energy, Hematinic Plastules can do wonders to restore her well-being.



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The Canadian Nurse

VOLUME 46

NUMBER 5

MAY, 1950

NEW PRODUCTS.....	340
REPORT OF GENERAL SECRETARY.....	G. M. Hall 347
REPORT OF TREASURER.....	G. M. Hall 353
THE CANADIAN NURSE JOURNAL.....	M. E. Kerr 357
THE EDITORIAL BOARD.....	M. S. Mathewson 358
COMMITTEE ON INSTITUTIONAL NURSING.....	E. M. Palliser 359
COMMITTEE ON PRIVATE DUTY NURSING.....	B. Key 360
COMMITTEE ON PUBLIC HEALTH NURSING.....	T. G. Hunter 361
COMMITTEE ON CONSTITUTION, BY-LAWS AND LEGISLATION.....	N. D. Fidler 364
EDUCATIONAL POLICY COMMITTEE.....	A. J. Macleod 370
METROPOLITAN SCHOOL OF NURSING.....	N. D. Fidler 373
LABOR RELATIONS COMMITTEE.....	I. Broadfoot 374
COMMITTEE ON HEALTH INSURANCE.....	F.H.M. Emory 377
ARRANGEMENTS COMMITTEE.....	A. Wyness 378
COMMITTEE ON STUDENT NURSE ACTIVITIES.....	M. E. Kerr 380
PUBLIC RELATIONS COMMITTEE.....	H. G. McArthur 380
EXCHANGE OF NURSES COMMITTEE.....	N. S. Mackenzie 382
COMMITTEE ON ARCHIVES.....	E. A. E. MacLennan and Sr. J. Forest 382
LOAN AND BURSARY COMMITTEE.....	C. L. Townsend 384
WAR MEMORIAL COMMITTEE.....	M. E. Kerr 384
PROVINCIAL ASSOCIATION HIGHLIGHTS.....	386
NURSING PROFILES.....	388
STRENGTHENING THE HOME VISIT.....	S. Milley 390
THE PARAPLEGIC PATIENT.....	E. McKean 391
TETANUS.....	B. Rutherford 394
LE TRAVAIL D'EQUIPE EN NURSING.....	O. Préfontaine 396
HOW PEOPLE LIVE.....	T. Cormier 400
BOOK REVIEWS.....	405
NEWS NOTES.....	407

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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Manufacturer—Lederle Laboratories Division—North American Cyanamid Ltd., Montreal.

Description—A trivalent immunizing agent containing Purogenated diphtheria-tetanus toxoids, alum-precipitated, and pertussis vaccine Phase I.

Indications—For immunization of infants and children of preschool age against diphtheria, whooping cough, and tetanus. May also be used for the "booster" injection for children about to enter school.

CAUBREN COMPOUND TABLETS

Manufacturer—Whittier Laboratories Division—Nutrition Research Laboratories, Chicago; Canadian distributor: Laurentian Agencies Ltd., Montreal.

Description—Each tablet contains Chlorothen Citrate (antihistaminic) 25 mg., Acetophenetidin 320 mg., Caffeine 32 mg.

Indications—For symptomatic relief and to shorten the duration of the common cold.

Administration—As directed, as early as possible after onset of symptoms, preferably within 12 hours.

PREGNENOLONE

Manufacturer—John Wyeth & Bro. (Canada) Limited, Walkerville, Ont.

Description—Each tablet contains 100 mg. of the acetate of the synthetic steroid compound, Pregnenolone.

Indications—For trial in rheumatoid arthritis.

Administration—Oral dosage employed in clinical trials has been between 100 and 300 mg. By intramuscular injection 100 mg. daily has been used. Exact details of dosage have not been established.

METHADON

Manufacturer—E. B. Shuttleworth Chemical Co. Ltd., Toronto.

Description—The synthetic analgesic, d1-4,4'-diphenyl-6-dimethylamino-heptanone-3. In tablets of 5 mg. and 10 mg. In hypodermic tablets of 2.5, 5 and 10 mg. In sterile solution, 10 mg. per cc.

Indications—For the relief of pain, especially where morphine would be indicated. Fewer side effects than with morphine. Is of value in renal colic and in bladder spasm where morphine is of little value. Not suitable for preanesthetic medication or in obstetrics.

Administration—Orally or parenterally. Suggested doses: moderate pain, 2.5 mg. orally every 4 hours; severe pain, as with fractures or malignant tumors, 5 mg. orally or subcutaneously every 3 to 5 hours; severe pain of renal colic, post-operative pain after major surgery, 10 mg. subcutaneously every 4 to 6 hours.

PRESTO-BORO POWDER

Manufacturer—Standard Pharmaceutical Co., New York; Canadian distributor: Lyster Chemicals Ltd., Montreal.

Description—Each envelope contains sufficient powder to prepare a moist compress of 1:20 Burow's Solution N.F., when added to a pint of water.

Indications—Where external moist dressings of Burow's Solution are indicated.

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- BEREX is easily administered . . . reasonable in cost.

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BEREX may be obtained through your prescription pharmacy—in bottles of 100 tablets or in bottles of 500 tablets designed for dispensing and institutional use.

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Manufacturer—Mowatt & Moore Ltd., Montreal.

Description—Each tablet contains: Sodium carboxymethylcellulose 4½ gr.; Magnesium oxide 1½ gr.

Indications—Peptic ulcers. Protects, eases pain, neutralizes acid without producing constipation or diarrhea.

Administration—2 to 4 tablets 3 or 4 times a day between meals or as directed by the physician. Not to be chewed.

EXORBIN

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—A polyethylene polyamine methylene substituted resin of diphenylol dimethyl methane and formaldehyde in basic form; an anion exchange resin capable of lowering gastric acidity.

Indications—For control of gastric hyperacidity and as an adjunct to the treatment of gastric and duodenal ulcers.

Administration—Suggested dosage: Two or more tablets or one-half teaspoonful of powder in a small amount of milk or other liquid every two hours or as required.

PYRIBENZAMINE NEBULIZER

Manufacturer—Ciba Company Limited, Montreal.

Description—A convenient pocket or purse-size nebulizer containing 7.5 cc. of Pyribenzamine (Ciba brand of N'-pyridyl-N'-benzyl-N-dimethyl-ethylenediamine monohydrochloride).

Indications—Nasal symptoms due to hay fever, allergic rhinitis, other seasonal allergies, and common colds.

Administration—By inhalation as required.

METRASIL TABLETS

Manufacturer—Ward, Benkinsop & Co. Ltd., London; Canadian distributor: Brent Laboratories Ltd., Toronto.

Description—Each tablet contains 0.5 gm. and the solution 30% of para-sulfanilamido-salicylic acid, a compound sulfanilamide and para-amino-salicylic acid.

Indications—Pyelitis, cystitis, and urethritis due to infections by *Streptococcus faecalis*, *B. proteus*, *E. coli*, or *Ps. pyocyaneus*; for prevention of such infections following surgery of the genito-urinary tract.

Administration—Orally, supplemented by irrigation of urinary tract by neutral solutions of the sodium salt.

Dr. L. O. Bradley Appointed

Dr. Leonard O. Bradley of Toronto has been appointed executive secretary of the Canadian Hospital Council. He will assume his new duties on August 1. He is at present director of studies for the Ontario Health Survey Committee.

Dr. Bradley was born in Saskatchewan and was graduated in medicine from the University of Alberta in 1938. He served for five

years as a medical officer with the Royal Canadian Air Force at command headquarters in Winnipeg and throughout the western provinces. Dr. Bradley has an unusual knowledge of hospitals and their problems. His extensive clinical training, executive experience, and formal training in hospital administration form an excellent background for his new work.

A spectacular instance of the change for the better in the Canadian health picture is seen in diphtheria statistics. In 1929, there were 9,093 cases and 1,280 deaths from this

disease in Canada. In 1948, there were 898 cases and 85 deaths. With toxoid so readily available one might ask why the latter figures were still so high.

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- The Essential Elements . . . Proteins and Essential Amino Acids . . . Essential Amino Acid Content of Protein Foods . . .
- Conditioning Factors in Nutritional Disease . . . Chemical Tests for Detection of Malnutrition . . . The Metabolism and Action of Foods . . . Dietary Toxicology . . .
- Human Nutritive Requirements . . . The Diet of Health and Disease . . .
- Tables of Food Composition and Nutritive Value . . . Selected Bibliography.

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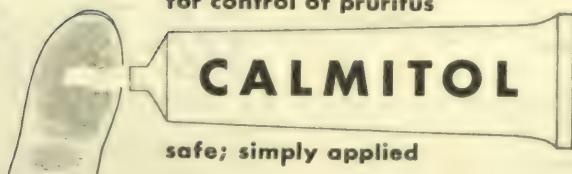
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Etiology is enigmatic and signs may be imperceptible in anogenital pruritus. But the itching is pronounced and relief imperative.

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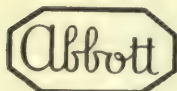
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Ascorbic Acid.....	40 mg.
Nicotinamide.....	10 mg.

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D, B₁, B₂, C AND NICOTINAMIDE, ABBOTT)

The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX

NUMBER FIVE

MONTREAL, MAY, 1950

Reports for the Biennial Period 1948-50

The reports of the various officers, chairmen, and conveners of committees of the Canadian Nurses' Association are presented in this issue so that every member may have an opportunity to study them before the convention in June.

Convention week is going to be a very full and busy time. In order that discussion on these reports may be full and to the point, the Executive Committee authorized this presentation in the May issue instead of in June as in 1948. It is recommend-

ed that every association that is sending a representative analyze these reports to provide a background of opinion.

None of these reports has been presented to the Executive Committee and must be accepted as tentative reports, subject to some slight revision when actually presented.

No mimeographed folios of these reports will be prepared by our National Office so it is earnestly requested that you—

BRING THIS COPY WITH YOU!



Report of General Secretary

CONTRARY to predictions made during and immediately following the war, the Canadian Nurses' Association has not expanded its program of activities for the reason that finances have restricted the development of

programs which have been proposed from time to time.

During the past biennium there has been the usual routine organization work and this has included the preparations for four Executive meet-



ings and for the biennial meeting. Preparing for and carrying out the follow-up work resulting from these meetings is time-consuming. To a very considerable extent, copies of correspondence received in National Office must be made and channeled to the various committees and organizations concerned.

CHANGES IN PERSONNEL

Miss Winnifred Cooke, assistant secretary, resigned in October, 1948, to become director of nurses at the General and Marine Hospital, Owen Sound, Ont. From October, 1948, till May, 1949, Miss Marion Nash assisted the general secretary on a part-time basis and from the latter date she has been employed full time. In addition to other duties, Miss Nash has been responsible for the planning and arrangement for the Work Conferences.

Owing to the increased clerical work in preparation for a biennial meeting an additional stenographer has been employed since October 15, 1949.

MEMBERSHIP

The total membership of the Canadian Nurses' Association reported to National Office as of December 31, 1948, was 26,350 and December 31, 1949, 28,358—an increase of 2,592 members since December 31, 1947.

INTERNATIONAL COUNCIL OF NURSES

Considerable time was devoted to answering lengthy questionnaires, preparing reports, and supplying information for headquarters, as well as for various committees, of the I.C.N. prior to the Conference in Sweden. All applications from Canadian nurses attending the Conference were cleared through National Office.

ADVISORY SERVICE

Much of our time is devoted to dealing with numerous enquiries and requests for information received from federal government departments, international and national organizations, prospective applicants to schools of nursing, and graduate nurses seek-

ing information and advice on selecting post-graduate experience. Some of these enquiries, accompanied by the inevitable lengthy questionnaire, require hours of searching and compiling and much of this work must be done after office hours.

Numerous enquiries are received from nurses all over the world concerning nursing opportunities in Canada. Requests for information and material are also made by nurses and others engaged in research work. One such request was received in May, 1949, from a young woman at Harvard University who had worked on the compilation of nursing legislation for the International Council of Nurses. She was writing a thesis on "Nursing Legislation" for her doctorate degree. Since time and staff did not permit searching out material from the C.N.A. archives, an invitation was extended for her to visit National Office where all the available material was placed at her disposal. The student spent nine days searching records and gathering data.

Requests for information concerning exchange privileges for nurses have been received from various countries; the majority continue to come from Britain.

C.N.A. PUBLICATIONS

There have been no new publications during this biennium. The pamphlets entitled "Facts About Nursing in Canada" and "Salary Schedules" have been revised. At the request of C.N.A., the Department of National Health and Welfare has undertaken the revision of the recruitment booklet "What You Want to Know About Nursing." The department has also prepared and published—in cooperation with National Office—the supplement to *Canada's Health and Welfare* entitled "Nursing—a Career for Women."

A Proposed Curriculum for Schools of Nursing in Canada and the *Supplement to a Proposed Curriculum for Schools of Nursing* are now out of print. It was decided to advertise in *The Canadian Nurse* for used copies, to be re-sold at a nominal fee.

PRESS CLIPPING SERVICE

The C.N.A. continues to subscribe to the Canadian Press Clipping Service and, three times a week, bulky brown envelopes make their appearance on the assistant secretary's desk. These clippings bring news about health work, especially about Canada's new health legislation and what is being done with all the millions of dollars voted to help keep Canadians well; news of hospitals and nursing—some good, some not so good; some that make interesting and pleasant reading because the message carried is one of progress; others again make the news, it is true, but we often pause and question why.

What do we do with them? First they are scanned for important new developments. Is there something going on that the general secretary should know? These are brought to her notice. The interesting bits we think others will enjoy are assembled, typed and checked, a stencil is made and finally the mimeographed copy is ready for assembling. These are distributed mainly through the provincial nursing association offices.

INTERNATIONAL VISITORS

Hospital administrators and members of hospital governing boards have been among the continual stream of international visitors. An administrator from a large hospital in Switzerland spent considerable time in National Office seeking information on administration of schools of nursing in Canada. He informed us that the hospital he represented did not employ a nursing director; each of the 30 head nurses employed reported directly to the hospital administrator. We arranged a program of visits to hospital schools of nursing in Canada where he could see a director of nursing in action.

Many requests are also received from various organizations, as well as from hospitals, for programs of observation and experience for nurses. In some instances, due to the difficulties connected with currency exchange, we are asked to arrange

hospitality. We are deeply grateful for the cooperation and kindness of many hospital administrators who have met these requests with such courtesy.

COOPERATION WITH WORLD HEALTH ORGANIZATION

The Pan-American Sanitary Bureau in Washington is now serving as regional headquarters of the World Health Organization for the western hemisphere. National Office was requested to assist in finding a French-speaking nurse for the health program being inaugurated under WHO in Haiti last April. Every available assistance was sought in order to meet the need. Finally, with the cooperation of the director of nurses and the medical director of the Montreal Department of Health, a member of their staff was released for a period of one year to undertake this work.

A second request was received early in January, 1950, for a French nurse, skilled in pediatric nursing, to serve in a hospital in Paris. The same procedure was followed and applications were submitted.

NATIONAL ACTIVITIES

During the past biennium there have been several changes in provincial registrars and we record once again our appreciation of the cooperation of the registrars. The untimely death of Miss E. Frances Upton soon after her retirement brought grief to us all.

REGISTRARS' CONFERENCE

A very successful conference was held in Montreal, November 6 and 7, 1949, immediately preceding the Executive meeting. The discussion centred around: an evaluation program for schools of nursing; assistance to nurses from displaced persons camps to qualify for registration; reciprocal registration, and other matters of general interest to registrars.

NURSES FROM DISPLACED PERSONS CAMPS

At the request of the Deputy Minister of Labor, Ottawa, National

Office staff has assisted the federal authorities responsible for interviewing and placing these nurses. Credentials were checked and assistance was given in their placement in hospitals conducting schools of nursing. Forty-four nurses have been placed to date. A duplicate of the information obtained from the nurses regarding their preparation and experience was also sent to the secretary of the provincial nurses' association concerned.

Progress report forms were prepared and distributed, through the cooperation of provincial secretaries, to the directors of hospitals employing these nurses. Copies of these reports, when received, were forwarded to the Department of Labor. The latter has indicated approval of and satisfaction with this assistance given by the C.N.A.

NATIONAL COMMITTEES

Assistance has been given during the period of re-organization following the biennial meeting and later as requested.

A manual of directives concerning the functions of national and special committees, and the provincial counterparts of the former, was prepared by National Office, submitted to the Committee on Constitution, By-laws and Legislation, and subsequently to the provincial associations for comment and/or approval. It was finally mimeographed and distributed to all the above-mentioned groups in January, 1950.

ATTENDANCE AT MEETINGS

In September, 1948, the general secretary, as a representative of the Canadian Florence Nightingale Memorial Committee, attended meetings of the Grand Council, Florence Nightingale International Foundation, held in London, and later accompanied the president to meetings of the Board of Directors, I.C.N.

In June, 1949, the general secretary again represented the Canadian F.N.M.C. at meetings of the Grand Council, F.N.I.F., held in Stockholm, and also attended the Board of Directors and Grand Council meetings of

the I.C.N. Following the I.C.N. Conference, the general secretary attended the international conference of national secretaries held at Bergendal, Sweden.

FIELD WORK

As no provision was made in the budget for travelling expenses for members of National Office staff, field visiting has been sharply curtailed during the past biennium. At the request of the New Brunswick Association of Registered Nurses, the general secretary attended and addressed the annual meeting of the association in Edmundston and later conferred with the director and members of the Provincial Health Survey Committee on matters related to nursing.

Talks on nursing affairs have also been given by the general secretary to various groups and organizations. The assistant secretary attended and participated in meetings of the Joint Planning Commission for Adult Education. A report of the work done by the C.N.A., on behalf of nurses from displaced persons camps, was submitted to the above Commission and, as a result, we were asked by the Canadian Citizenship Council to release the report for publication in their journal.

VISIT TO NEWFOUNDLAND

At the request of the Newfoundland Graduate Nurses' Association, the general secretary spent two weeks there during February for the purpose of studying the nursing situation and with a view to making recommendations which could be considered by that association in their future plans.

When it was learned that registration is not a requirement for membership in the present association and, inasmuch as the present administration of the Registration Act does not entirely conform with the registration requirements in other provinces, it was recommended that an effort be made by N.G.N.A. to secure a Licence Act for Nurses. At the time of writing this report, the whole matter was under consideration by the Newfound-

land association and no definite action had been taken concerning the above recommendation. It is, however, confidently expected that the nurses of Newfoundland will ultimately become organized as a registered nurses' association and affiliated with the Canadian Nurses' Association.

REPRESENTATIONS TO FEDERAL GOVERNMENT

In accordance with a resolution adopted at the general meeting on July 1, 1948, a brief was presented to the Department of National Health and Welfare requesting the establishment of a division of nursing within the Department of National Health and Welfare, with a fully qualified nurse as director. In November, 1948, the president and general secretary, together with members of the sub-executive, attended a meeting of the Advisory Committee to the Department of National Health and Welfare. This meeting was held for the purpose of conferring with the directors of Health Surveys on all matters concerning the Federal Health Grants.

STATISTICAL REPORT

*(Prepared by Miss M. Archibald,
Statistical Worker, National Office)*

During the past biennium, the practice was established of preparing three annual questionnaires to secure the following data:

(a) During August or September—information on the withdrawal rate of student nurses; reasons for withdrawal; and the number of students who yearly enter schools of nursing.

(b) In January—information on the

number of students enrolled in schools of nursing as of December 31. The enrolment is classified as to length of time in training—i.e., Preliminary, 1st, 2nd and 3rd-year student.

(c) In April or May—a questionnaire to university schools for graduate nurses to estimate enrolment in the various courses.

From the foregoing, yearly statistical data are assembled and comparisons are made with previous years.

Schools of nursing are classified according to the bed capacity of the hospital in which they are located or which serves as their clinical field. There are nine categories, beginning with hospitals having bed capacity of 51-100 and increasing by 100 until the 7th classification takes in 601-900 beds, and the last over 900 beds. This latter classification was divided to separate general hospitals with large classes from mental hospitals with small classes.

Schools of nursing in the first two categories make up almost half of the total number of schools of nursing in Canada, and give training to less than one-quarter of the student nurses. This is in contrast to hospitals of 500 beds and over, that train 37% of the students in 15% of the schools. Eleven mental hospitals conduct schools for 2% of the students.

It is interesting to note that, since 1931 when Dr. Weir conducted his survey, the schools of nursing in hospitals with:

Bed capacity of 55-99 have decreased from 77 to 23.

Bed capacity of 100-300 have increased from 62 to 84.

DISTRIBUTION OF SCHOOLS OF NURSING AND STUDENT NURSES ACCORDING TO THE SIZE OF THE HOSPITAL

<i>Bed Capacity</i>	<i>% of Schools</i>	<i>% of Students</i>
51—100.....	13.6	4
101—200.....	32	17.7
201—300.....	18	17.2
301—400.....	11.7	17.7
401—500.....	2.6	4
501—600.....	6	12
601—900.....	4.8	13
Over 900.....	4.8	12
Mental Hospitals.....	6.5	2.4

PERCENTAGE OF GRADUATES ON STAFF QUALIFIED BY POST-GRADUATE STUDY			
Bed Capacity of Hospital	Superintendent	Instructor	Supervisor
	Asst. Supt.	Educ. Dir.	Head Nurse
	%	%	%
51—100.....	45	58	11
101—200.....	49	63	23
201—300.....	49	70	25
301—400.....	60	74	20
401—500.....	50	89	20
501—600.....	71	87	26
601—900.....	90	84	34
Over 900.....	77	91	22
Mental Hospitals.....	31	20	2

Bed capacity of over 300 have increased from 32 to 62.

Students in training have increased about 66%—from just over 9,000 in 1931 to 14,115 as of January 1, 1950. The number who will be graduating in 1950 has increased 44% over the number graduating in 1940.

The return on the questionnaires forwarded to all hospitals in Canada two years ago averaged 65% but from hospitals with schools of nursing it was 87%. From these data an attempt was made to show the number of teaching and administrative personnel on the staffs of hospitals and nursing schools in those hospitals, as well as the number of such personnel qualified by post-graduate study.

While giving figures on graduate nurses, it is interesting to note the changes in ratio of graduate nurses in the major fields of nursing.

Though the number of graduate nurses employed in public health has doubled, the percent of total nurses actively engaged in nursing remained much the same during the last 20 years—i.e., 15% of the total.

Statistics on University Schools for Graduate Nurses show that approximately 500 nurses yearly receive diplomas or certificates—a drop of 100 in the last four years, possibly due to the decrease in the number of nursing sisters attending university.

As well as yearly questionnaires, occasionally the C.N.A. is asked to do a *spot study*. Two of the spot studies conducted in 1949 were as follows:

- (a) Percentage of various types of nursing service personnel in hospitals based on 26 hospitals of various bed capacities.
- (b) Reasons for graduate nurse turnover and included in the same question-

MAJOR FIELDS OF NURSING						
	1930		1943*		1948**	
	Number	%	Number	%	Number	%
Private Nursing.....	6,370	60	6,327	29	2,886	15
Institutional.....	2,639	25	10,705	48	12,846	67
Public Health.....	1,521	15	1,885	9	2,377	13
Industrial.....	..	..	1,356	6	640	3
Other Fields and unspecified.....	..	..	1,849	8	287	2
Total.....	10,530		22,122		19,036	

* (a) Compulsory federal registration of all nurses.

** (b) Based on returns—Hospitals, approx. 65%; private nursing, approx. 91%; public health nursing, approx. 85%.

In 1930 the ratio of Private Nursing to Institutional was 60 to 25.

“ 1943 “ “ “ “ “ “ “ “ 29 to 48.

“ 1948 “ “ “ “ “ “ “ “ 15 to 67.

naire was "Need for Male Nurses." Out of 51 hospitals replying, 31 answered that they would use male nurses if available and 10 schools would accept them for training. A report of the vacancies on the staff of 51 hospitals at that time (June, 1949) reported a shortage of:

Superintendent of nurses.....	1%
Instructors.....	10%
General Duty.....	65%
Auxiliary personnel.....	24%

Graduate nurse turnover is distributed as follows: The greatest turnover was in general duty which was—90%; next, supervisors and head nurses which was—8%; last, superintendents and instructors which was—2%. Eighty per cent of those resigning from the staff had been employed by the hospital for a year or less.

These figures are just a few examples from the data assembled from

questionnaires that have been prepared and analyzed during the past biennium and will, we hope, give some indication of the value of the statistical service provided by National Office.

CONCLUSION

In closing this report the National Office staff wishes to express appreciation to the Executive Committee and to the members of the Canadian Nurses' Association for the support received from them during the past biennium.

To my co-workers in National Office who render loyal and efficient service at all times—a very special word of appreciation is extended.

GERTRUDE M. HALL
General Secretary

Report of Treasurer

THE METHOD of preparing financial statements was revised during the past biennium—a comparative statement in relation to the proposed budget for the biennium was used. By this method the members of the Executive Committee are informed of the monthly current expenditures and total expenditures for the current period of the biennium.

Upon recommendation of the Committee on Finance, approved by the Executive Committee in January, 1949, a token grant of 25 cents per member was requested from each provincial association with the result that a total, to date, of \$5,940.17 has been received.

Commissions from Thos. Cook & Son Ltd. for the sale of tickets for tours at the time of the International Council of Nurses Conference in Sweden amounted to \$2,849.73.

In accordance with the decision of the International Council of Nurses to double the amount of the affiliation fee, the C.N.A. Executive Committee

instructed the treasurer to forward the affiliation fees for 1949 at the rate of 16 cents per member (Canadian funds). In the future the affiliation fee, based on 8 pence per member, will be paid when due at the current rate of exchange for pounds sterling. The sum of \$4,025.25 was forwarded for 1949.

Due to an increased membership of 2,592 during this biennium, the revenue has also increased by \$2,592.

Early in September, 1949, the treasurer was informed that Dominion of Canada Bonds, bearing 3% interest, maturing 1952, were being called in October. The Canadian Nurses' Association held these bonds to the amount of \$2,000. Upon consultation with the auditor, we were advised to secure Canadian National Railways Bonds, guaranteed by the Dominion Government, bearing interest at the rate of 2½%, maturing September 15, 1969. Upon approval of the president, the above-mentioned bonds were purchased.

At the request of the International Council of Nurses, the nurses of Canada contributed the sum of \$1,095 for assistance to nurses in war-devastated countries. This money was collected by the provincial associations and forwarded by the C.N.A. to the I.C.N.

The last instalment of the Government Grant from the Department of National Health and Welfare, amounting to \$9,718.40, was received on July 30, 1948, and was allocated

as follows:

British Columbia.....	\$1,349.40
Saskatchewan.....	2,200.00
Quebec.....	3,000.00
Ontario.....	950.00
Nova Scotia.....	1,125.00
National Office for administration.....	1,094.00

Total—GOVERNMENT GRANT.. \$9,718.40

GERTRUDE M. HALL
Treasurer

CANADIAN NURSES' ASSOCIATION

BALANCE SHEET AS OF DECEMBER 31, 1949

Assets

CURRENT ASSETS

Cash on hand and in bank.....	\$15,196.44
Affiliation fees outstanding.....	2,178.00
Dominion of Canada and other bonds at cost— (par value \$18,200).....	18,251.37
	<u>35,625.81</u>

LOAN FUND

Cash in bank.....	\$ 7,090.26
Loans to member nurses.....	2,448.87
	<u>9,539.13</u>

Furniture and fixtures, less depreciation.....	696.66
	<u>45,861.60</u>

SPECIAL FUNDS

<i>The Canadian Nurse Journal Fund</i>		
Cash in bank.....	832.80	
Dominion of Canada bonds at cost— (par value \$3,500).....	3,500.00	4,332.80
<i>War Memorial Trust Fund—Library</i>		
Cash in bank.....		17,063.43
<i>Mary Agnes Snively Memorial Fund</i>		
Cash in bank.....	335.18	
80 shares Bank of Montreal at cost.....	2,144.00	2,479.18
<i>National Memorial Fund</i>		
Cash in bank.....	6.73	
15 shares Royal Bank of Canada at cost.....	305.00	311.73
<i>Nurses' Assistance Fund</i>		
Cash in bank.....		100.36
TOTAL SPECIAL FUNDS.....		<u>24,287.50</u>
		<u>\$70,149.10</u>

Liabilities

CURRENT LIABILITIES

Sundry accounts payable.....	\$ 60.00
Advances for commercial exhibits.....	550.00

SURPLUS

Amount at December 31, 1948.....	\$37,337.41	
Add net revenue for the year ended December 31, 1949.....	7,914.19	45,251.60
		<u>45,861.60</u>

SPECIAL FUND RESERVES—PER CONTRA

<i>The Canadian Nurse Journal Fund</i>	4,332.80	
War Memorial Trust Fund—Library.....	17,063.43	
Mary Agnes Snively Memorial Fund.....	2,479.18	
National Memorial Fund.....	311.73	
Nurses' Assistance Fund.....	100.36	24,287.50
		<u>\$70,149.10</u>

STATEMENT OF REVENUE AND EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 1948

REVENUE

Affiliation fees.....		\$26,350.00
Grant from the Department of National Health and Welfare.....	\$ 9,718.40	
<i>Less—Amounts distributed to Provincial Associations</i>	8,624.40	1,094.00
Interest received.....		709.80
Curricula and Supplements.....		384.48
Sales of pamphlets, Orations, etc.....		606.75
Miscellaneous.....		190.52
<i>Florence Nightingale Memorial Foundation Fund:</i>		
Donation from Canadian Red Cross.....	400.00	
Proceeds from sale of Oration.....	154.00	
		554.00
<i>Less: Contribution to cost of survey</i>	\$ 404.56	
Telephone and sundry charges.....	8.12	412.68
		141.32
		<u>29,476.87</u>

EXPENSES

Salaries.....	12,784.33	
Rent.....	1,650.00	
Insurance.....	67.20	
Telephone and telegrams.....	494.83	
Light and water.....	119.09	
Audit and legal fees.....	275.00	
<i>Travelling expenses:</i>		
Executive.....	5,207.38	
General.....	1,598.31	6,805.69
Stationery and printing.....	1,042.66	
Office supplies and expenses.....	736.22	
Multigraphing and stencils.....	413.37	
Advertising—Official Directory.....	330.00	
Library.....	303.80	
Press clippings.....	289.92	
Official entertainment.....	27.64	
Postage and excise.....	404.27	
Depreciation—10% on furniture and fixtures.....	85.78	25,829.80
		<u>3,647.07</u>

DEDUCT

1948 biennial meeting:

Expenses.....	8,989.81	
<i>Less Revenue</i>	5,806.00	3,183.81

International Council of Nurses:

Affiliation fees.....	2,061.28	
Travelling expenses.....	1,414.38	
Travel allowance.....	250.00	3,725.66

Bursaries and expenses (1947 & 1948).....	1,064.17	
Educational Policy Committee expenses.....	772.62	8,746.26

Excess of Expenses over Revenue..... \$ 5,099.19

STATEMENT OF REVENUE AND EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 1949

REVENUE			
Affiliation fees.....		\$28,358.00	
Interest received.....		710.49	
Curricula and Supplements.....		247.10	
Sale of pamphlets.....		443.36	
Token grant.....		5,831.42	
Commissions.....		2,849.73	
Donation—educational purposes.....		250.00	
Royalties on book sales.....		21.22	
Miscellaneous.....		110.00	
<i>Florence Nightingale Memorial Foundation Fund:</i>			
Donation from Canadian Red Cross.....	\$	75.00	
Donation from Canadian Nurses' Association.....		75.00	
		150.00	
Less sundry charges.....		20.00	130.00
Donations for assistance to nurses in devastated countries.....			1,095.00
Profit on the sale of bonds.....			25.00
			<u>40,071.32</u>
EXPENSES			
Salaries.....		13,263.31	
Rent.....		1,950.00	
Unemployment insurance.....		90.38	
Telephone and telegrams.....		512.84	
Light and water.....		142.65	
Audit and legal fees.....		363.35	
<i>Travelling expenses:</i>			
Executive.....		4,423.07	
General.....		357.13	
Stationery and printing.....		362.78	
Office supplies and expenses.....		414.35	
Multigraphing and stencils.....		298.98	
Advertising—Official Directory.....		320.00	
Library.....		178.83	
Press clippings.....		401.95	
Official entertainment.....		21.93	
Insurance, general.....		59.13	
Postage and excise.....		319.40	
Bank charges.....		25.59	
Depreciation on furniture and fixtures.....		174.16	23,679.83
			<u>16,391.49</u>
DEDUCT			
Biennial meeting—postage.....		48.75	
<i>National Committees—Meetings and Projects:</i>			
Educational Policy Committee.....	\$	746.10	
National Committee.....		238.98	985.08
Donation, Florence Nightingale International Foundation.....		75.00	
<i>International Council of Nurses:</i>			
Fees.....		4,216.00	
Travelling expenses.....		2,057.47	6,273.47
Assistance to nurses in devastated countries.....		1,095.00	8,477.30
Net Revenue for year ended December 31, 1949.....			<u>\$ 7,914.19</u>

Alberta, Too!

Another momentous telegram has brought good news to the *Journal*. At their recent annual meeting, the members of the Alberta Association of Registered Nurses voted to incorporate the subscription to *The Canadian Nurse* in their annual active registration fee. This makes the third provincial association to give their wholehearted support in this fashion to their own nursing *Journal*. New Brunswick, Prince Edward Island, Alberta! Who will be next?

The Canadian Nurse Journal

Editorially speaking, this has been an exceedingly successful biennium for the *Journal*. A high calibre of articles covering a wide range of topics of genuine interest to nurses has been provided. The cooperation of busy medical men, nurses, and others in preparing such outstanding scientific and professional articles is genuinely appreciated. Reprints have been made of many of the articles and in numerous instances permission has been given for reprinting our material in contemporary periodicals, including their translation into some foreign languages.

We continue to be greatly indebted to Miss Suzanne Giroux for her unflagging interest in securing articles for our special French-language section and in being personally responsible for the translation into French of the releases from National Office.

A new feature which was added in June, 1949—"New Products"—has been very well received. This material is compiled by the *Canadian Pharmaceutical Journal* and is published under an arrangement with that organ.

Each of the special interest groups has cooperated actively in maintaining the flow of articles for their pages.

Circulation: The considerable drop early in this biennium which followed the increase in subscription rates has been overcome and paid circulation is again over the 10,000 mark. Approximately 25 per cent of these subscribers are student nurses which means that a relatively small proportion of the total number of the graduate nurses in Canada are personal subscribers. This situation has been sharply altered in New Brunswick where the members of the Registered Nurses' Association voted unanimously at their convention in September, 1949, to include the subscription to *The Canadian Nurse* in the fees paid annually to their association. This arrangement became effective in March, 1950. A resolution has been

passed by the nurses of Prince Edward Island to amend their by-laws to include the subscription to the *Journal* with their fees. Consideration of a similar step is being given by other provincial nurses' associations. This whole-hearted support is most encouraging.

An effort has been made to establish a special subscription agency in countries within the sterling bloc. So far it has been found impossible to surmount the currency problems.

Cumulative Index: Since 1944, we have published an index each year which is available to any subscriber upon request, without charge. This year we have prepared a cumulative index for each of two periods—1940-44 and 1945-49. Owing to the small number of copies required these volumes have been mimeographed and are for sale at the price of \$1.00 per copy. It is planned that eventually all the material in the *Journal*, right back to its founding in 1905, will be similarly indexed.

Financial picture: A noted publishing accountant wrote recently: "To publish any periodical today costs 65 to 75 per cent more than the same issue in the same quantity cost in 1939." In an endeavor to maintain the same high quality of printing, each issue during 1949 was limited to 80 pages. Other expenditures were kept at a minimum also. As a result, the *Journal* ends this biennium in a somewhat happier financial position.

Advertising: Normally a solid source of income to a periodical, it has been increasingly difficult to maintain a steady quantity of commercial advertising. The provincial committees, authorized to assist in securing advertising contracts from local sources, have proved of negligible value.

Visits to provinces: In the interests of economy, very few trips have been made during this biennium. However, it is worthy of note that, during the past five years, visits have been paid and addresses delivered in 96 per

cent of the schools of nursing in Canada. Large numbers of meetings with graduate nurse groups have also been addressed.

Office personnel: Miss Kathleen Williams, secretary to the editor, has been promoted to be assistant business manager. The activities at the *Journal* office are currently carried on by a staff of five.

Editorial Board: The biennium was started with the reappointment of the same members as had guided the *Journal's* activities previously. Following the resignation of Miss Fanny

Munroe, Miss Isobel Black was appointed to the Board by the Executive Committee, C.N.A. It has been a continuing source of strength to the editor to have the entire board resident in Montreal for ease in consultation. Appreciation is expressed to them for their ready assistance and advice at all times. The generous help and counsel given by the general secretary of the C.N.A. is also gratefully acknowledged.

MARGARET E. KERR
Editor and Business Manager

The Editorial Board

It is with regret that the resignation of Miss Fanny Munroe is recorded. Miss Munroe had been a member of the Board since its inception and her interest and sound counsel will be missed. Miss Isobel Black was named to replace Miss Munroe.

The state of *The Canadian Nurse*, financial and otherwise, is well described in the report of the editor and business manager and needs little further comment.

The paid circulation picture is encouraging and is again over the 10,000 mark. It might be in order to point out that in July, 1944, when the present editor took office and the Editorial Board was appointed, the circulation figure was 5,278. It is also interesting to note that the estimated budget for 1950 is just double that of 1944.

The diminishing financial returns from advertising are a cause of some concern and new contracts are being actively pursued. It is hoped that the recent trend toward increased advertising activity will soon reach the *Journal*. Nurses themselves could assist in retaining contracts now held if they mentioned the fact that they saw a product advertised in *The Canadian Nurse*, and in securing new business by asking the manufacturers why certain commodities of interest to nurses are not advertised there.

The editor is to be congratulated on the completion of the first volume of the Cumulative Index (1940-44) to the *Journal*. This is a real accomplishment and one which will meet a long-felt need.

MARY S. MATHEWSON
Chairman

In their first year at a school for the blind, the young children are in the kindergarten class where the teacher will mainly show them how to get the feel of everything and make them discover with their hands what the world is like. With bricks and blocks, animal figures and other models, they get ideas of the things they cannot see. They also learn their alphabet and are taught to write Braille.

Their progress compares most favorably with that of seeing children; a blind child learns to read and to write just as quickly as a seeing child of the same I.Q. Indeed, intelligent blind students seem to be ahead of their seeing brothers in many respects. The reason may be that they concentrate more on their studies, that their attention is much less distracted from studies by what surrounds them.

—Ontario Government Services

Committee on Institutional Nursing

MEMBERS OF THE EXECUTIVE of the committee include:

Chairman—Elinor M. Palliser, director of nursing, Vancouver General Hospital; Vice-chairman—Sister Columkille, director of nursing, St. Paul's Hospital, Vancouver; Secretary-treasurer—Edna Rositer, matron, Shaughnessy Hospital, Vancouver; Convener, Publications Committee—Ida Johnson, director of nursing, Royal Alexandra Hospital, Edmonton. Members—Jessie Young, superintendent of nurses, Kitchener-Waterloo Hospital, Kitchener, Ont.; Dorothy Potts, director of nursing, General Hospital, Belleville, Ont.; Cynthia Bing, assistant head nurse, Vancouver General Hospital; Mrs. K. D'Arcy Goldrick, general staff nurse, St. Vincent's Hospital, Vancouver.

Frequent meetings of the local members were held in Vancouver during the biennium and minutes were distributed to all members. Reports were received from the provincial Committees on Institutional Nursing at the times designated—January and June of each year—and these reports were incorporated into the reports to the Executive Committee.

Ida Johnson is the convener of the sub-Committee on Publications. Interesting articles from six provinces have been received and forwarded for publication each month on the special page in the *Journal*. Three provinces have not submitted any articles.

The following projects were discussed at the regular meetings of the core committee and decision was made to present them to the Executive:

1. *Geriatric Nursing Institute*: This was the unanimous choice of the core committee as an important and timely project for the provincial Committees on Institutional Nursing to consider and, if possible, adopt in the form of institutes, refresher courses, topics at annual meetings, etc. Accordingly, an enlarged committee meeting was held in Vancouver on June 28, 1949, representing 21 related as-

sociations and institutions of Vancouver and including an attendance of 31 interested persons. This was a very stimulating meeting—suggestions were received from all groups and all seemed to be of the opinion that care of the chronic, convalescent, and older patients is one of the outstanding needs at the present time. The project was, therefore, presented at the meeting of the C.N.A. Executive in November, 1949, and it was agreed that this was a project which might be adopted by each provincial committee as convenient and advisable. Letters from eight of the directors of nursing of leading hospitals across Canada confirmed the need and timeliness of this project.

Several of the provincial committees have since agreed that the topic's adoption will be considered at the monthly meetings of the provincial registered nurses' associations. *Alberta* has decided to hold a one and one-half day institute on Geriatric Nursing, preceding the annual provincial meeting in April, 1950. *Ontario* has planned an evening symposium on "The Lengthening Life Span" in April, at a special annual meeting session. A report of these will be submitted at the C.N.A. biennial convention in June.

2. *The ratio between graduate nurses and nurse aides*: This project was taken over, upon a suggestion from the Executive Committee, at the post-convention meeting in Charlottetown, in July, 1948.

Jessie Young very willingly accepted the convener'ship of a sub-committee to study "the most equitable ratio between graduate nurses and nurse aides, to ensure the best and safest nursing care." Miss Young's committee consisted of: Dorothy Potts; Sister Mary Grace, superintendent of nurses, St. Mary's Hospital, Kitchener; Jessie Wilson, assistant superintendent, Runnymede Convalescent Hospital, Toronto; and Carol Adams, associate director of nursing education, and Lillian Campion, associate director of nursing service, both of Kitchener-Waterloo Hospital. Dr. Sellers, medical statistician of the Ontario Department of Health, was called in, in

consultation. A questionnaire was drawn up and distributed by the provincial associations to their various hospitals. Up to February 23, 1950, of the 780 questionnaires sent out to hospitals by the provincial registered nurses' associations, 450 had been returned. Final results of the findings will be presented at the biennial meeting in June.

From the reports of the provincial Committees on Institutional Nursing, the following activities were outstanding:

1. Two institutes on ward teaching and supervision, one in Regina and one in Saskatoon, conducted by Mary Tschudin—Saskatchewan.
2. Studies on the "Brown Report"—Saskatchewan.
3. A workshop on "Workshop Techniques"—Saskatchewan.
4. An institute on ward teaching and supervision, conducted by Mrs. Tschudin in Edmonton, Alta., and attended by 150 nurses representing 35 hospitals.
5. An institute on geriatric nursing—Alberta.

6. A refresher course in floor supervision—Prince Edward Island.

7. An evening symposium on "The Lengthening Life Span," as a special annual meeting session of the Registered Nurses' Association of Ontario.

8. A three-day institute for head nurses, conducted by Gladys B. Carter, B.Sc.—Quebec (English).

9. A series of conferences on basic principles in nursing education—Quebec (French).

I should like to take this opportunity of thanking every member of the national Committee on Institutional Nursing for their willing and interested cooperation in the duties and plans of their national committee. It has been a pleasure to work with them. I should like to recommend most sincerely that the incoming committee will consider the continuing of the interest in geriatric and related nursing as a project for the next biennium.

ELINOR M. PALLISER
Chairman

Committee on Private Duty Nursing

THE CORE COMMITTEE held three meetings to discuss and prepare a manual for guidance of registries and placement bureaus for private duty nursing in Canada. All other business has been done by correspondence.

Eighteen articles were forwarded to *The Canadian Nurse* for publication on the Private Duty Nursing Page. One of these articles was in the body of the magazine—"Summary of Clinical Laboratory Procedures" by Dr. E. M. Watson of London, Ont. This article was prepared as one of the lectures in the educational program conducted by the Community Nursing Registry in London.

Many requests were received, asking for information regarding the setting up of registries, shared nursing,

educational programs, financing registries, etc.

Fees for private duty nurses have been increased in all provinces—\$7.00 for 8-hour duty being the most popular, with \$8.00 in a few centres. In the Maritimes the fee is \$6.00. A few provinces are charging 50 cents extra for the afternoon and evening periods. Most provinces are attempting to set a uniform fee throughout.

Educational programs are being conducted in several provinces. They are very beneficial and popular. Nurses from all fields of nursing are taking advantage of this method of keeping up with newer trends.

Shared nursing is increasing in favor with more nurses and patients participating in this type of service.

Financing registries seems to be a

general problem. Telephone services are being offered to related groups by many registries—i.e., doctors, visiting nursing organizations, Red Cross, etc. This, as well as sponsoring bridges, concerts, etc., has helped with finances. Fees for registry membership have been increased in most centres.

The conference for registrars and presidents of boards of directors of community nursing registries, which is conducted annually in Ontario, has been most valuable in the conduct of registry work. There are 27 organized

registries in Ontario, which participate in this program by sending one or two representatives each year. This form of education has broadened the value of the registry service to the community as well as to the nurse.

There still exists a shortage of private duty nurses with many calls going unfilled. Hospitals are requesting a goodly number of nurses for relief with general staff duty to cover the shortage in that field.

BARBARA KEY
Chairman

Committee on Public Health Nursing

SINCE THE GENERAL meeting of 1948 in Sackville, four meetings of the Committee have been held. Several of the chairmen of the provincial Public Health Committees were changed in 1948 which created some delay in the activities of the provincial committees in this biennium. Ruth Morrison accepted the office of vice-chairman and Marjorie Pinchbeck the chairmanship of the Publications Committee. In accordance with a resolution passed in 1948, concerning a liaison between the C.N.A. and the C.P.H.A., the chairman of the Nursing Section of the Canadian Public Health Association, Helen Carpenter, became a member of the C.N.A. Public Health Committee.

OLD BUSINESS

Publications: With Miss Pinchbeck as convener, the committee feels that articles for *The Canadian Nurse*, although following no main theme, have all been well prepared and well worth reading. It is noted with interest the increasing number of articles on nursing in industry which have been published on this page.

There is certainly no dearth of good material but some suggestions of ways of unearthing the nurses who can and

would write articles would be welcomed.

National Public Health Nursing Day: At the meeting in 1948, it was reported that a joint effort to interpret the function and work of the public health nurse in the community was being undertaken by the C.P.H.A. and the C.N.A. Committee on Public Health Nursing. This project was abandoned as being untimely after being given thoughtful consideration by members of the two committees who were to act together. A recommendation went forward to the C.P.H.A. in 1949 asking that the committee be dissolved.

Recommendations on qualifications and minimum salaries for public health personnel in Canada: A copy of the revised recommendations as prepared by the C.P.H.A. and published in the *Canadian Journal of Public Health* in April, 1949, was received. This committee has no knowledge of the extent to which these recommendations have been met by official and voluntary agencies across the country in the past two years, but in the figures published by the C.P.H.A., based on material gathered in 1948, a substantial increase over 1946 in starting salaries for positions requiring qualified public

health nurses had been noted.

The statement in the report that "the recruitment and maintenance of staff is the major problem facing agencies today" is still probably true one year later, although professional training grants under the Federal Health Grants have certainly helped in this regard. The recommendations of the Public Health Committee made in 1948 have, therefore, been met as far as revision and publication of these recommendations is concerned.

Job Analysis Study: The study conducted by the C.P.H.A., through funds supplied by the Kellogg Foundation and directed by Dr. Baillie and Lyle Creelman, was completed in 1949 and, at the time of writing, the published report has not yet been received. Each province assisted materially with this study and the findings and recommendations of Miss Creelman and her advisory committee will be of interest to all.

Training of registered nurses for midwifery: A resolution was forwarded to the C.N.A., suggesting that this matter be referred to the Educational

Policy Committee, and that they be asked to include in their considerations suggestions as to the ways in which the Committee on Public Health Nursing could enter into any developments proposed. No further action has been taken by the Public Health Committee in this regard.

CURRENT BUSINESS

Public health grants: The announcement by the Hon. Paul Martin in 1948 that health grants would be made available to each province has stimulated the work of all health agencies and made possible developments which were in the minds of many health workers as rather impossible dreams. Public health nursing has shared in making some of these dreams come true and reports received from the provinces indicate great developments in establishing new services, in enlarging existing ones, and in experimenting with special projects.

It is particularly interesting to note the number of nurses who have been awarded bursaries for study—some to obtain their basic training but many

DISTRIBUTION OF PUBLIC HEALTH NURSES

	P.E.I.	N.B.	N.S.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
1. No of Nurses:									
In official agencies..	7	24	41	521	615	117	89	97	218
In voluntary " ..	..	31	45	215	not	24	9	17	57
In P.H. clinics.....	1	1	92 (?)	90	stated	9	4	28	17
In industry (with and without P.H. training).....	..	..	4	260	500 app.	24	4	2	27 app.
Others.....	..	9	10	11	36	5	3	..	2
Total.....	8	65	192	1097		179	109	144	321
2. No. of meetings of P.H. Comm. since 1948.....	0	6	2	7	4	5	..	4	7
3. No. of P.H. meetings (general) since 1948.....	4	20	2	4	2	13	1	3	2
6. Bursaries awarded to P.H. personnel...	9	12	23	1*	52	9	not	29	14
						(3 VON)	stated		

* Only one known to chairman.

to obtain advanced training in special fields of public health nursing.

Report of study of public health nursing activities: It is hoped that this report will be available for study at the time of the general meeting in June.

Reports from provinces: The following guide was sent to the provincial committees in January to be completed and returned for inclusion in this report:

1. Number of nurses engaged in public health nursing in your province—

- (a) In official agencies
- (b) In voluntary agencies
- (c) In public health clinics (T.B., V.D., O.P.D.)
- (d) In industry with P.H. training
- (e) Any others

2. Number of meetings of Public Health Nursing Committee held since June 30, 1948.

3. Number of public health general meetings held since June 30, 1948. (Include any planned before June 15, 1950.)

4. List and describe briefly any special activities of the committee in this biennium.

5. Describe briefly any expansion in public health in your province during this biennium (e.g., new areas opened; industry; special projects).

6. Were any bursaries awarded in your province to public health nursing personnel? Describe briefly.

A summary of the information obtained from those returned is included with this report.

4 & 5. Without reference by provinces, the following highlights were noted as special activities and expansion of public health in Canada:

(a) Opening of new clinics and health units, including mental hygiene clinics in several provinces.

(b) A new Division of Maternal and

Child Health in one provincial Department of Health.

(c) Extension of Red Cross nursing stations.

(d) Addition of a public health nurse to the staff of two colleges to initiate health education courses and the addition of public health nurses to Normal School staffs.

(e) One new university school of nursing has been opened to provide the basic course in public health nursing.

(f) Health surveys of all health services have been carried out in some of the provinces.

(g) Institutes have been arranged by the industrial nurses in two provinces and institutes for supervisors and senior nurses were arranged in two provinces.

(h) Classes in home nursing, conducted by volunteer nurse instructors, were sponsored by the Canadian Red Cross in one province.

(i) One provincial committee is working towards obtaining coverage for pulmonary tuberculosis for public health nurses by the Workmen's Compensation Board.

The detailed reports from each province will be available at the meeting in June.

Conclusion: Although your committee feels that they have not been very active, it is with pleasure we note the activity of the various provincial committees. Probably the most useful function a national committee of this sort can perform is to be available to receive suggestions from provincial committees and to act as a coordinator of these suggestions. We hope we have fulfilled our function in this regard and that the incoming committee will not experience too much difficulty in carrying on where we leave off.

TRENNA G. HUNTER
Chairman

Rates by Rail to Vancouver

The Canadian Pacific Passenger Service has notified the Canadian Nurses' Association that there will not be any excursions to Vancouver during the period of the biennial meeting. The Standard Certificate Plan, as outlined in the March issue of this *Journal* on page 213, will afford the most economical mode of travel.

Committee on Constitution, By-Laws and Legislation

Following the biennial meeting of June, 1948, the digest of provincial Nursing Acts was revised and brought up to date at December, 1948.

In accordance with the resolution passed by the Executive Committee in January, 1949, that a more detailed directive for national committees be prepared, the general secretary-treasurer sent a draft outline of this directive to your convener in April, 1949. This was examined by your committee and comments returned to the secretary-treasurer, who has distributed the national committee manual to the provincial associations.

AMENDMENTS TO BY-LAWS

The following amendments to the By-laws of the Canadian Nurses' Association were approved at a meeting of the Committee on Constitution, By-laws and Legislation held on February 21, 1950. They were submitted to the Executive Committee on March 10, 1950, and approved. They are submitted herewith for the consideration of the general meeting in Vancouver. For convenience, the present By-law is quoted opposite the suggested amendment thereof.

NETTIE D. FIDLER
Chairman

PRESENT BY-LAW

SUGGESTED AMENDMENT

BY-LAW I

ANNUAL MEMBERSHIP FEE

Section 2. An annual membership fee of \$1.00 per member shall be collected by the Provincial Association to which each nurse belongs and shall be remitted to this Association by the said Provincial Association on March 31st, June 30th, September 30th or December 31st following the date of collection as the case may be.

Section 2. Commencing January 1st, 1952, an annual membership fee of \$2.00 per member shall be collected by the Provincial Association to which each nurse belongs and shall be remitted to this Association by the said Provincial Association on March 31st, June 30th, September 30th and December 31st following the date of collection as the case may be.

BY-LAW II

EXECUTIVE COMMITTEE COMPOSITION

Section 1 (d). Five representatives from the Nursing Sisterhoods to be chosen on a regional basis from among the Ordinary Members in such manner as may from time to time be prescribed by the Executive Committee.

Section 1 (d). Five representatives from the Nursing Sisterhoods.

That the Regions be defined as follows:

1. The Three Maritime Provinces
2. Quebec
3. Ontario
4. Manitoba, Saskatchewan
5. Alberta and British Columbia

Section 1 (e) (vi) The Committee on Labour Relations.

Section 1 (e) be amended by the deletion of (vi) The Committee on Labour Relations.

BY-LAW IV

TERM OF OFFICE

Section 2. All elected officers shall hold

Section 2. All elected officers, chairmen of

PRESENT BY-LAW

office until the conclusion of the next General Meeting after their election. No officer shall be elected to the same office for more than two consecutive terms.

SUGGESTED AMENDMENT

national committees, representatives of the Nursing Sisterhoods and members of the Nominating Committee shall hold office until the conclusion of the next General Meeting after their election or appointment. No officer, chairman of a national committee, representative of the Nursing Sisterhoods or member of the Nominating Committee shall be elected or appointed to the same office for more than two consecutive terms.

BY-LAW V

**NOMINATING COMMITTEE
COMPOSITION**

Section 1. There shall be a Nominating Committee of five members, two of whom shall be appointed by the Executive Committee and three of whom shall be elected by ballot by the Voting Delegates at each General Meeting.

Section 1. There shall be a Nominating Committee of five members, of whom the Chairman and one other member shall be appointed by the Executive Committee and three members shall be elected by ballot by the Voting Delegates at each General Meeting. Each Provincial Association shall submit at least two names for the elected members of the Nominating Committee.

BY-LAW V**CHAIRMAN AND SECRETARY**

Section 2. The Chairman of the Nominating Committee shall be chosen from among its members by the members of the Committee at its first meeting. The General Secretary of the Association shall act as Secretary of the Committee.

BY-LAW V**SECRETARY**

Section 2. A member of the secretarial staff of the Association shall act as Secretary of the Committee.

BY-LAW V**REQUEST FOR NOMINATION**

Section 3. On or before the 1st day of October preceding the next General Meeting of the Association, the Secretary of the Committee shall request each Provincial Association to nominate at least one candidate for each of the offices and elected chairmanships of National Committees in the Association, which candidate must be qualified to hold such office or chairmanship.

Section 3 (a). The Conference or Conferences of Sisterhoods in each Region—namely: the Maritime Provinces; Quebec; Ontario; Manitoba-Saskatchewan; Alberta-British Columbia—shall be requested to appoint from their Nurse Membership a Selections Committee.

The Secretary of the Nominating Committee shall request each Regional Selections Committee to submit, by September 30th preceding the next General Meeting of the Association, the names of at least two Sisters who have consented to serve if elected, with a short biography of each person listed.

Section 3 (b). On or before the 31st day of October preceding the next General Meeting of the Association, the Secretary of the Committee shall request each Provincial Association to nominate at least one candidate for each of the elected memberships on the Executive Committee of the Association.

BY-LAW V**SUBMISSION OF NOMINATIONS**

Section 4. All Provincial Associations shall submit to the Secretary of the Committee on or before the 31st day of December fol-

Section 4. All Provincial Associations shall submit to the Secretary of the Committee on or before the 31st day of December following,

PRESENT BY-LAW

lowing, all nominations made by them, which nominations must be signed on behalf of such Associations by the President and the Secretary thereof. Every nomination must be accompanied by a consent, signed by the person nominated, agreeing to serve if elected.

SUGGESTED AMENDMENT

all nominations made by them, which nominations must be signed on behalf of such Associations by the President and the Secretary thereof. In submitting nominations for representatives of the Nursing Sisterhoods, Provincial Associations shall make provision that each Region is represented. Every nomination must be accompanied by a consent, signed by the person nominated, agreeing to serve if elected.

BY-LAW V**MANNER OF NOMINATING**

Section 5. The Secretary of the Committee shall send a copy of all nominations so received to each member of the Nominating Committee as soon as possible after the said 31st day of December. The members of the Committee shall carefully consider all the nominations received and shall select therefrom for each office and chairmanship the names of the two candidates who have received the highest number of nominations for such office or chairmanship, provided however that if there be more than two candidates for any office or chairmanship who have received the highest number of nominations by reason of any equality of nominations among them, then all such candidates so receiving the highest number of nominations shall be so selected. As soon as the list of candidates has been so prepared it shall thereafter be known as the "Ticket of Nominations," and a copy of it, signed by the Chairman and the Secretary of the Committee, shall be sent not later than the 31st day of March following, to each Provincial Association.

Section 5. The Secretary of the Committee shall send a copy of all nominations so received to each member of the Nominating Committee as soon as possible after the said 31st day of December. The members of the Committee shall carefully consider all the nominations received and shall select therefrom for each elected membership of the Association the names of the two candidates who have received the highest number of nominations for such elected membership, provided however that if there be more than two candidates for any elected membership who have received the highest number of nominations by reason of any equality of nominations among them, then all such candidates so receiving the highest number of nominations shall be so selected. As soon as the list of candidates has been so prepared it shall thereafter be known as the "Ticket of Nominations," and a copy of it, signed by the Chairman and the Secretary of the Committee, shall be sent not later than the 31st day of March following, to each Provincial Association.

BY-LAW V**QUALIFICATION FOR NOMINATION**

Section 7. Any person nominated for any office or chairmanship in the Association must be an Ordinary Member in good standing of the Association.

Section 7. Any person nominated for any elected membership in the Association must be an Ordinary Member of the Association in good standing.

BY-LAW V**NOMINATION**

Section 8. No person may be nominated for any office or chairmanship in the Association except by the Nominating Committee, and no nomination may be made other than in the manner above set forth. The Chairman of the Nominating Committee shall file a copy of the Ticket of Nominations with the President of the Association before the next General Meeting of the Association, and the filing of such a copy with the President shall constitute the official nomination of the parties therein named to the offices and chairmanships in question.

Section 8. No name may be added to the Ticket of Nominations for any elected membership in the Association except by the Nominating Committee, and no nomination may be made other than in the manner above set forth. The Chairman of the Nominating Committee shall file a copy of the Ticket of Nominations with the President of the Association before the next General Meeting of the Association, and the filing of such a copy with the President shall constitute the official nomination of the parties therein named to the elected memberships in question.

PRESENT BY-LAW

SUGGESTED AMENDMENT

BY-LAW V

PROVISION FOR ADDITIONAL NOMINATION

Section 9. In case any of the candidates nominated by the Nominating Committee should die, refuse in writing to stand for such office or chairmanship, be unable to do so, or become disqualified in any way from so doing before any election takes place, any Voting Delegate may nominate for any such office or chairmanship any Ordinary Member of the Association whose name was put in nomination for any office or chairmanship to the said Nominating Committee, and any nomination so made must be filed with the President before the election.

Section 9. In case any of the candidates nominated by the Nominating Committee should die, refuse in writing to stand for such elected membership, be unable to do so, or become disqualified in any way from so doing before any election takes place, any Voting Delegate may nominate for any such elected membership in the Association any Ordinary Member of the Association whose name was put in nomination to the said Nominating Committee for any elected membership, and any nomination so made must be filed with the President before the election.

BY-LAW VI

ELECTIONS AND VOTING—VOTING BODY

Section 1. The Voting Body at each General or Special Meeting of the Association shall consist of the Voting Delegates from the Provincial Associations.

BY-LAW VII

MOTIONS AT GENERAL MEETINGS

Section 7. On all questions which have been previously submitted to the Association Members only Voting Delegates shall be permitted to vote. On all other questions where the policy of the Association is not involved, any ordinary member may move, second, and vote in such manner as the Chair may decide.

BY-LAW VI

VOTING DELEGATES

Section 2, 2nd par. Membership as used in this section shall mean members who are fully paid-up members of and in good standing with the Provincial Association in question.

BY-LAW VI

By-Law VI, Section 1—Elections and Voting—Voting Body—and By-Law VII, Section 7—Motions at General Meetings—to be replaced by:

BY-LAW VI—ELECTIONS AND VOTING—VOTING BODY—MOTIONS AT GENERAL MEETINGS:

Section 1. At each General or Special Meeting of the Association, the Voting Body shall consist of the Voting Delegates from the Provincial Associations on all questions which have been submitted previously to the Association Members and on all elected memberships. On all questions where the policy of the Association is not involved, any Ordinary Member may move, second, and vote in such manner as the Chair may decide.

Section 2, 2nd par. Membership as used in this section shall mean members who are fully paid-up members of and in good standing with the Provincial Association in question and for whom the Provincial Association has paid the annual membership fee mentioned in *By-Law I, Section 2.*

BY-LAW VI

VOTING RIGHTS OF VOTING DELEGATES

Section 3. Each Voting Delegate shall have, at least, one vote for each office and chairmanship in the election of officers and chairmen, and on all matters which come before any General or Special Meeting. Any Provincial Association may, however, give and grant to any one or more of its Voting Delegates the right to cast in addition to her own vote, any number of votes up to a number not to exceed for all Voting Delegates of such Provincial Association the total number of votes to which such Association is entitled

Section 3. Each Voting Delegate shall have, at least, one vote for each elected membership in the election of members on the Executive Committee of the Association, and on all matters which come before any General or Special Meeting. Provincial Associations having obtained the consent of a candidate to stand for office shall guarantee to that candidate the total votes of that Province. Any Provincial Association may, however, give and grant to any one or more of its Voting Delegates the right to cast in addition

PRESENT BY-LAW

under the provisions of *Section 2* of this *By-Law VI*. Each Provincial Association must certify in writing under the signature of its President the number of votes which each Voting Delegate may cast, which writing must be delivered to the General Secretary prior to the commencement of the General or Special Meeting in question.

BY-LAW VI**ELECTION OF OFFICERS AND CHAIRMEN**

Section 8. The elective Officers and Chairmen of the Association shall be elected by ballot at the General Meeting. The candidate receiving the highest number of ballots for each office and chairmanship shall be declared elected by the Chairman. For elections the polls shall be open for a period of two hours from the time that the voting commences. Each Voting Delegate shall individually cast her vote or votes.

BY-LAW VIII**APPOINTMENT OF NATIONAL AND SPECIAL COMMITTEES**

Section 3. The members of all National Committees shall be appointed by the Executive Committee at its first meeting after each General Meeting to serve until the conclusion of the next General Meeting. Only Ordinary Members in good standing of the Association may be appointed to Committees. Special Committees may be appointed by the President or the Executive Committee at any time.

BY-LAW VIII**COMMITTEE ON INSTITUTIONAL NURSING**

Section 5. The Committee on Institutional Nursing shall:

- (a) Implement policies of nursing education and practice as recommended by the Committee on Educational Policy and approved by the Executive Committee.
- (b) Be concerned with:
 - (i) Special problems of administration, supervision and teaching in Hospitals and Schools of Nursing;
 - (ii) Nursing Service, both graduate and undergraduate.
- (c) Promote public interest in Hospitals and Schools of Nursing.
- (d) Promote a higher standard of service through post-graduate study.

BY-LAW VIII**COMMITTEE ON PRIVATE DUTY NURSING**

Section 6. The Committee on Private

SUGGESTED AMENDMENT

to her own vote, any number of votes up to a number not to exceed for all Voting Delegates of such Provincial Association the total number of votes to which such Association is entitled under the provisions of *Section 2* of this *By-Law VI*. Each Provincial Association must certify in writing under the signature of its President the number of votes which each Voting Delegate may cast, which writing must be delivered to the General Secretary prior to the commencement of the General or Special Meeting in question.

BY-LAW VI**ELECTED MEMBERS OF EXECUTIVE COMMITTEE**

Section 8. The elective members of the Executive Committee of the Association shall be elected by ballot of the Voting Delegates at the General Meeting. The candidate receiving the highest number of ballots for each elected membership shall be declared elected by the Chairman. For elections the polls shall be open for a period of two hours from the time that the voting commences.

Section 3. The members of all National Committees shall be appointed by the Executive Committee at its first meeting after each General Meeting to serve until the conclusion of the next General Meeting. Only Ordinary Members of the Association in good standing may be appointed to Committees. Special Committees may be appointed by the Executive Committee at any time.

Section 5. The Committee on Institutional Nursing shall:

- (a) Be concerned with:
 - (i) Special problems of administration, supervision and teaching in Hospitals and Schools of Nursing;
 - (ii) Nursing Service, both graduate and undergraduate.
- (b) Promote public interest in Hospitals and Schools of Nursing.
- (c) Promote a high standard of service.
- (d) Establish a mutual understanding between nurses engaged in institutional nursing and other branches of the profession.

BY-LAW VIII**COMMITTEE ON PRIVATE NURSING**

Section 6. The Committee on Private

PRESENT BY-LAW

Duty Nursing shall endeavor:

- (a) To establish and maintain a constructive and sympathetic relationship among all Nurses engaged in Private Duty Nursing in Canada.
- (b) To establish a mutual understanding between Nurses engaged in Private Duty Nursing and Nurses in other branches of the profession.
- (c) To promote a higher standard of service through post-graduate study.

SUGGESTED AMENDMENT

Nursing shall endeavor:

- (a) To establish and maintain a constructive and sympathetic relationship among all Nurses engaged in Private Nursing in Canada.
- (b) To establish a mutual understanding between Nurses engaged in Private Nursing and Nurses in other branches of the profession.
- (c) To promote a high standard of service.

BY-LAW VIII**COMMITTEE ON PUBLIC HEALTH NURSING**

Section 7. The Committee on Public Health Nursing shall endeavor:

- (a) To establish and maintain a constructive and sympathetic relationship among all Public Health Nurses.
- (b) To keep the Association informed upon the progress of Public Health Nursing;
- (c) To advance the cause of Public Health in general by fostering a high standard of service;
- (d) To promote a higher standard of service through post-graduate study.

Section 7. The Committee on Public Health Nursing shall endeavor:

- (a) To establish and maintain a constructive and sympathetic relationship among all Public Health Nurses;
- (b) To keep the Association informed upon the Progress of Public Health Nursing;
- (c) To advance the cause of Public Health in general by fostering a high standard of service.

BY-LAW VIII**COMMITTEE ON FINANCE**

That the following functions of the *Committee on Finance* shall be included under *By-Law VIII, Section 15.*

The Committee on Finance shall:

- (a) Recommend to the Executive Committee for presentation to the General Meeting a budget for the forthcoming biennium.
- (b) Make recommendations with respect to financial matters to the Executive Committee.
- (c) Act in an advisory capacity on financial matters to the President and General Secretary between meetings of the Executive Committee.

Re-number present Sections 15, 16 and 17 of By-Law VIII.

BY-LAW XII**AMENDMENTS**

Section 1. These By-laws or any Section thereof may be added to, repealed, amended or re-enacted at any time by a majority vote of those Voting Delegates present and voting at any General or Special Meeting of the Association. Notice of any proposed amendment must be given to the General Secretary at least three months prior to the date of any General or Special Meeting at which the amendment is to be voted upon and a copy

Section 1. These By-laws or any Section thereof may be added to, repealed, amended or re-enacted at any time by a majority vote of those Voting Delegates present and voting at any General or Special Meeting of the Association. Notice of any proposed amendment must be given to the General Secretary at least three months prior to the date of any General or Special Meeting at which the amendment is to be voted upon and a copy

PRESENT BY-LAW

of the said notice must, within one month after the receipt thereof by the General Secretary, be mailed by her to each Association Member. The notice must contain full particulars of the proposed amendment and be signed by two Association Members as proposer and seconder respectively.

SUGGESTED AMENDMENT

of the said notice must, within one month after the receipt thereof by the General Secretary, be mailed by her to each Association Member.

Educational Policy Committee

AS ONE ATTEMPTS to review the past two years, in the light of the tasks we set for this committee, we seem to have spent a great deal of time discussing what we should be doing. Actually very little has been accomplished, except our part in the demonstration school project and in the formulation of plans for the next committee.

During this biennium the following people have been members of the Committee on Educational Policy: Chairman, Miss A. J. Macleod; vice-chairman, Miss M. Street; secretary, Miss I. Black; Sr. J. Forest, Misses E. K. Russell, N. D. Fidler, M. E. Kerr, E. Mallory, E. Young, G. Sharpe, G. M. Hall, E. Cryderman (*ex officio*). Sub-committee conveners: Instruction, Sr. Trottier; auxiliary workers, Miss L. Fair. Four meetings have been held.

When the last biennial report was prepared, we were just ready to get underway on the demonstration school. Much of that report dealt with the preliminary steps which had been taken—the securing of a director, finding a hospital to cooperate in the proposed demonstration, and setting up the joint committee. This was known as the Demonstration School Administration Committee, comprised of the full membership of the Educational Policy Committee as well as three Red Cross representatives. Since that time, we have found it impossible, frequently, to secure a quorum. Hence, a recom-

mendation was approved by the Executive Committee that there should be a reduction in membership of the Demonstration School Administration Committee. It now includes the three Red Cross representatives and three members representing the C.N.A. Details concerning the demonstration school will be included in a separate report.

When making my report two years ago, I referred to the questions concerning educational policy which had been discussed, such as: the training of male nurses; the relationship of the Council of University Schools and Departments of Nursing to the Canadian Nurses' Association; the value of central schools; the need for an evaluation program; curriculum content of the future; who should support nursing education; and the need of a full-time secretary for educational work at National Office. Now, as I summarize again, I realize that many of the questions are still facing us. However, we may be a little nearer their realization than we were.

EXTENDED MEMBERSHIP

At the first meeting of the biennium it was proposed that each provincial association should be encouraged to appoint an Educational Policy Committee if it had not already done so, these committees to follow the national pattern of representing all nursing interests. It was also recommended that the chairmen of such provincial committees would be cor-

responding members of the National Committee on Educational Policy. These two recommendations were adopted by the Executive Committee.

EVALUATION AND ACCREDITATION OF SCHOOLS OF NURSING

In regard to this problem, recognized as a necessary future step, it was decided that we should study the methods used by the Canadian Catholic Hospital Council in setting up its evaluation program. It was agreed that the C.N.A. should develop a good basic program of evaluation as soon as possible. Eventually this would lead to accreditation of schools of nursing. A small provisional committee was set up to study the whole question. Already some articles on evaluation have appeared in *The Canadian Nurse*. One of the work conferences is to be conducted by the members of that small committee. It is hoped that this conference may be a decisive step toward the development of a Canadian evaluation program. It is anticipated that institutes and evaluation may be an early project once the educational secretary is appointed.

WORK OF SUB-COMMITTEES

The question arose as to the advisability of having sub-committees, or whether it is better to appoint special committees for specific purposes, terminating them when their particular function has been achieved. At that time two sub-committees were discontinued: (1) Male Nurses; (2) Public Health Nursing Functions. This left two sub-committees: (1) Auxiliary Workers; (2) Instruction. Neither of these has been very active, although meetings have been called. However, there has not been sufficient liaison with the Committee on Educational Policy. It is believed that if an educational secretary were available to keep correspondence going back and forth to such sub-committees, they might be able to appreciate their national significance better than they do as presently constituted in the locality of the convener. They are rarely represented on the C.N.A.

Executive Committee or in touch with provincial groups interested in the same problems.

At the last meeting of this committee it was decided that possibly sub-committees should exist only at the provincial level and that, nationally, only special committees should be appointed for specific studies. Consequently, it was recommended to and approved by the Executive Committee that the sub-Committee on Instruction should be discontinued. It was agreed that the sub-Committee on Auxiliary Workers should continue as such for the time being, with the recommendation that the committee make an effort to broaden the scope of its studies in order to embrace the national picture.

EDUCATIONAL REFRESHER COURSE

A letter was received from the Association of Nurses of the Province of Quebec concerning a proposed centralized course for a special group of European nurses. The question was raised as to whether financial assistance might be obtained to defray expenses incurred in setting up their program. It was decided to recommend that the War Memorial Fund be drawn upon up to the sum of \$500 for such a purpose. The Executive Committee approved. The Quebec nurses decided, however, that they would assume full responsibility themselves. It seems to have been a very worthwhile project and, from all reports, the nurses benefitting by the program are loud in their praise and very appreciative of what has been done for them.

FIRST AID COURSE FOR STUDENT NURSES

The accelerated course in First Aid, which the Canadian Red Cross Society is willing to make available to schools of nursing, has been reviewed and approved by this committee. The following motion was approved by the Executive Committee:

That the accelerated course in First Aid for student nurses, as recommended by the Red Cross Society, should be approved, in lieu of the development of the

First Aid Course by the Canadian Nurses' Association, as proposed by the Executive Committee in 1946.

NEED FOR AN EDUCATIONAL SECRETARY

It is the opinion of all the members of this committee that we should again reiterate our previous recommendation:

That an Educational Secretary should be appointed to the staff of National Office, particularly in view of the necessity for developing a national program of evaluation.

NURSING CARE STUDY

To determine the answer to this question, "How is nursing care for the people of Canada to be provided in any health service plan?", a study is proposed. Two years ago we spoke on this subject. The outcome was a resolution sent to the provinces to enquire if the nurses believed we should seek assistance from the government for nursing education. The provincial associations agreed that government support was to be desired, providing the nursing profession was able to keep control of the educational standards, etc.

In the meantime, federal money has been made available to the provinces in the form of health grants. One of the main developments has been provincial surveys, the results of which we are still awaiting. From the comments heard and the information already available, one would gather that there is a recognition on the part of the government of the fact that nursing will be the biggest problem.

The Executive Committee directed the Educational Policy Committee to prepare a tentative study plan for discussion. The chairman drew up a possible plan, indicating the need for a study. In order to have a detailed plan available to present at this C.N.A. meeting and in order that a director for it might be appointed at an early date and the main committee be set up for a study to commence in the early autumn, it was necessary to appoint an Interim Committee. The functions outlined were:

- (1) To put the plan in suitable form;
- (2) to estimate the overall costs;
- (3) to review groups whose interests should be represented on the main national committee membership;
- (4) to review the suggested names of possible choices for a director of the study;
- (5) to explore known financial resources regarding their interest and possible support of the plan.

Later it is anticipated that, if the proposed plan is approved, the main committee, as well as the Nursing Liaison Committee, will be set up to replace the Interim Committee.

The broad purpose of this project is to secure the understanding of the public in relation to the whole health service situation in so far as it affects nursing services, both professional and auxiliary. With the public's influence and support we would search for the best solution to the problem of providing the country with fully-qualified personnel in sufficient numbers to meet Canada's health service nursing requirements. We have been assured time and again that nursing has the sympathetic appreciation of the Canadian people, but that we have been too reticent to discuss our problems with the people who might see the wider implications and be in a position to initiate reforms.

During the past biennium it has been brought home to us very frequently that we need money if the C.N.A. is going to achieve any of the programs we know are long overdue—such as evaluation and accreditation of schools of nursing, independent schools, central schools, as well as better public interpretation and relations. The health of Canada is everybody's business. Therefore the preparation of sufficient people to care for the health of Canadians is everybody's business. We have come to the conclusion that the Canadian nurses must take the initiative. It is recommended that we seek financial assistance other than from government and ask representative people to act on a main committee, along with the director, and to join with us in seeking the answer to our question.

We need a blueprint of the whole Canadian scene. The provincial sur-

veys will give some of the data. Other information may, of necessity, have to be sought elsewhere. If gradually the whole mosaic can be appreciated and the correct solutions recommended, possibly the C.N.A. can still be the means of solving, with the help of interested fellow Canadians, its present dilemmas, growing in stature meanwhile, and remain master of her fate, rather than going down to mediocrity and insufficiency as some people presently fear we may. Never before was it so necessary for us Canadians to be united in our common interests and in nursing this is doubly true. We need a united front—a common trust—and a team-work attitude in order to go forward to our ever widening professional responsibilities. Therefore we in the C.N.A. must think nationally of what is best for our fellow Canadians and in serving them best we will also be serving our own best interests. The sub-executive, acting as the interim committee with Miss Fidler as convener, has pre-

pared a plan which is the first step in setting this study in motion. I hope you will give it your most earnest consideration and approbation.

CONCLUSION

May I say how very much I have enjoyed my contacts in this committee and how much I shall miss them. However, if the proposed structure study brings forward a better appreciation of our responsibilities within our profession, if we achieve a national educational secretary as well as a study initiated by the C.N.A. in which we gain the support of the public, and thus move forward to the solution of many of our present problems, the members of this committee may well feel that their time was not spent in vain during 1948-50, and that our discussions served as the preparation for the new advances which we all trust Canadian nursing may take during 1950-52.

AGNES J. MACLEOD
Chairman

Metropolitan School of Nursing

ADMINISTRATION

School building: Late in August, the school moved to the new building erected by the Metropolitan Hospital and the city of Windsor. This is a very fine building. Its completion made possible the taking of another class in September, 1949. A description of the building was in *The Canadian Nurse* Feb. 1950.

Contract with the Metropolitan Hospital: It will be recalled that, by the original arrangement with the Metropolitan Hospital, the school was to assume all running expenses, while the hospital agreed to pay \$200 per student per year in consideration of the nursing care given by the students in their practice. Up to the summer of 1949 this payment had not been made and it seemed that it would be very difficult for the hospital to do so. It appeared that a revision of the contract was necessary and this was made last autumn. By the new contract the school waives the \$200 payment and the hospital undertakes

to provide to the school light, heat, laundry, and the care of the grounds.

STUDENTS

Three groups of students have been admitted as follows:

January, 1948—13 students: British Columbia—1; Saskatchewan—2; Manitoba—1; New Brunswick—1; Ontario—8.

September, 1948—24 students: British Columbia—2; Saskatchewan—1; Manitoba—1; Prince Edward Island—1; Ontario—19.

September, 1949—24 students: Alberta—1; Saskatchewan—6; Manitoba—1; Quebec—1; Prince Edward Island—1; Ontario—14.

Of the first group, one was found unsuited to nursing and one left to be married. The remaining 11 graduated on February 18, 1950. One student in each of the remaining two groups was found unsuited to nursing.

Another class will be taken in September, 1950.

REGISTRATION

Registration examinations, Ontario: Part I, which is written ordinarily at the end of the first year of training, is written by our students at the end of eight months. The first two groups were all successful in this examination. The third group will write in April.

The graduating class were all successful in the final registration examination.

Reciprocal registration: In April, 1949, the provincial nurses' associations were asked if graduates of the Metropolitan School of Nursing would have the same privileges concerning reciprocity as the graduates of other approved Ontario schools. All the provinces have replied in the affirmative.

CURRICULUM

For the first class, just graduated, the curriculum as originally outlined has been followed with only minor adjustments, as follows:

Preliminary term

(largely classroom work in science and nursing).....	3 months
Medicine (including diet kitchen) 4	"
Surgery (including O.R.).....	4 "
Psychiatry.....	3 "
Obstetrics and pediatrics.....	6 "
Tuberculosis.....	1 month
Public health and communicable disease.....	1 "
Ward administration.....	1 "
Vacation.....	2 months

PUBLICITY

In addition to those in the press, articles about the school have appeared in 15 publications. There have been many enquiries from schools, hospitals, universities, and health departments. Since the opening of the school we have had more than 100 visitors, who came from Canada, England, the U.S.A., Europe, South America, and Asia.

NETTIE D. FIDLER
Director

Labor Relations Committee

RECOMMENDATIONS for personnel policies for nurses are well developed in British Columbia, Alberta, Saskatchewan, and Manitoba. Early in 1950, this committee was asked to draw up similar recommendations on a national basis, and I present the following statement, which has been approved by the Executive Committee for presentation to the general meeting.

May I ask that every nurse study this statement carefully. If this is ratified at this biennial meeting, the recommended personnel policies will be adopted as the official statement of the Canadian Nurses' Association.

INTRODUCTION

Nursing is a profession which exists to serve the sick and to promote the well-being of the community. In doing so the nurse is a co-worker with all others who seek to improve the welfare of mankind.

The professional nurse is prepared to assume those duties which are within the scope of her professional training but her services are limited to those for which she is prepared and public recognition of these rightful functions is essential.

The professional nurse is one whose status is maintained by registration and membership in a provincial registered nurses' association affiliated with the Canadian Nurses' Association.

The professional nurse serves all, regardless of race, creed, or social standing.

The professional nurse is committed to conduct which is consistent with a professional status in relation to her work and to her employer.

The C.N.A. is, therefore, properly concerned with defining and encouraging the adoption of those personnel practices which will promote a high quality of nursing service.

The policies set out herein are offered as a guide to both nurse employers and nurse employees in regard to Minimum Standards of Employment and Personnel Practices.

RECOMMENDED PERSONNEL POLICIES

The Canadian Nurses' Association has approved the principle of collective bargaining for professional nurses and recommends that it be done through their provincial registered nurses' association.

The following recommendations are made to all employers of registered nurses as the minimum standards of employment which have been endorsed by the C.N.A.

Conditions of employment: A definite and clear understanding between the nurse and the employer should be established regarding conditions of employment. This should be set forth in a written statement and a copy made available to both the employer and employee. It should cover policies regarding:

Responsibilities; salaries and increments; deduction of maintenance, if any; and time required for notification of termination of engagement by (a) employer, (b) nurse. Unless there are special arrangements satisfactory to both, notification of one month is recommended, except in case of a grave irregularity.

Inasmuch as a registered nurse maintains her legal professional status by annual membership and registration in a provincial registered nurses' association, it is recommended that such membership and registration be a requisite for employment—temporary or permanent.

Orientation program for new employees: The orientation of a new nurse is important because a worker's success depends to a great extent upon the manner in which she is introduced to her job. Therefore, every effort should be made to give the information and inspiration which a new employee needs. This should *not* be left to chance. Experience has proved that time and effort invested in developing skill and good morale pay good dividends, not only in terms of

efficient service, economical operation, and reduced employee turnover, but also in increased personal effectiveness, professional reputation, and goodwill.

Hours of work: The following general policies are recommended and are adaptable to any type of employment for nurses:

1. The maximum work week should be not more than 44 hours, the distribution of those hours to be based upon the nursing service needs of the hospital, agency, or employer.

2. Evening and night shifts should not be longer than two weeks and, where possible, a two-week period of day duty should follow each two-week period of evening or night duty, unless other arrangements are agreed upon by both the nurse and the employer. It is further recommended that the work week for evening and night duty be not more than 44 hours.

3. One full day off should be granted for each statutory holiday or in lieu thereof, namely: New Year's Day, Good Friday, Victoria Day, Dominion Day, Labor Day, Thanksgiving Day, Remembrance Day, Christmas Day, and others as may be proclaimed by civic, provincial, or national authorities from time to time.

Leave—A. Vacations: It is recommended that the following standards be considered as minimum for nurses:

Vacations with pay be granted on the following basis: After one complete year of service, 21 days; after 3 continuous years of service, 28 days.

B. That specifications regarding *terminal leave* and/or termination of employment should be made by each employer and incorporated with other personnel policies.

C. *Sick leave:* The following are recommended as minimum benefits which should be given with pay:

1. That sick leave be granted on the basis of 12 days per year.

2. That sick leave shall be cumulative, the employer to state the maximum amount of sick leave to which employees shall be entitled. The employer may require a physician's certificate for sick leave in excess of three days.

3. That nurse employees be required to be members of a prepaid hospitalization benefit scheme.

4. That a complete pre-employment physical examination with chest x-ray and a complete annual physical examination with chest x-ray be established as routine conditions of employment for nurses.

D. Leave of absence for studies: It is advantageous for hospitals and agencies to establish a policy for leave of absence of nurse employees for further study.

E. Leave of absence on salary and with expenses for staff members to attend nurses' meetings, conferences, and special study groups is a wise expenditure as it enables nurses to increase their knowledge and to exchange experiences which will result in better service.

Salaries: These will fluctuate in relation to the cost of living index. It is, therefore, desirable that these and other conditions of employment be reviewed yearly. The following principles are suggested to minimize misunderstanding and dissatisfaction regarding salaries:

1. Gross salaries should be paid and when maintenance (complete or partial) is provided by the hospital, the nurse should pay the hospital for (a) room, (b) meals.

2. Salary schedules should be based upon an established classification of nursing duties to be performed. [Note: For

a classification of hospital personnel, see "Job Analysis and Job Evaluation," procurable from the *Canadian Nurses' Association, 1411 Crescent St., Montreal 25.*]

3. Minimum and maximum salaries should be established for each type of nursing position.

4. Stated periodic increments should be given at least yearly, these increments to be given on the basis of satisfactory performance of duty.

5. A nurse with special post-graduate preparation and/or experience should receive a minimum of from \$10 to \$20 per month more than the salary of a nurse in a similar position who has not had such preparation or experience.

Residence: When circumstances necessitate residence accommodation, it should provide:

1. A residence apart from the hospital, with all living quarters above ground level.

2. A private bedroom for each nurse.

3. Adequate bathroom facilities for the use of the nursing staff only.

4. Facilities for personal laundry.

5. Facilities for social activities—i.e., living room and kitchenette.

Pension plans: Where a pension plan is not in effect it is recommended that the setting up of such a scheme, under a Dominion Government Annuity Plan, be investigated and established at an early date.

INA BROADFOOT
Chairman

Cellulose Sponges

This new product from Canadian Industries Limited, which is now being made in Canada, has possibilities for many uses in hospitals, clinics, laboratories—anywhere that a washing job has to be done. Made from specially prepared wood pulp cellulose, these sponges will hold 20 times their own weight of water. They are grit-free, soft and pliable when wet, and can be sterilized or cleaned by boiling. They float even when saturated. They can be cut to any desired shape or size—currently they are being made in five different sizes—in turtle-back and rectangular shapes. They are available through regular retail outlets.



Committee on Health Insurance

The terms of reference for this Committee as outlined by the Association were:

The Committee shall study carefully and keep in touch with Health Insurance schemes and have information available as may be required by the Association in the event of the adoption of a general plan of Health Insurance—federal or provincial.

Reviewing governmental efforts made during this decade towards the provision of health services for all Canadians, it is recalled that in 1943 the Canadian Nurses' Association presented a brief to the Advisory Committee on Health Insurance appointed by the Federal Government. It is observed further that, in the Heagerty Draft Bill, nursing was included with certain other professional services in the event of the enactment of permissive legislation for some form of national health insurance. Although such legislation has not been made effective to date, the Minister of Health of Canada has stated that the current grants provided by the Federal Government (and spent by the provincial governments) are for the express purpose of building up services and personnel which will make possible the effective implementation of such legislation when the time comes for its enactment.

Hence your committee, supported by the provincial committees on Health Insurance, is watching current developments so that when the governments—federal and provincial—agree upon some form of permissive legislation in this field, the C.N.A. will be prepared to state what, in the opinion of the national organization, the place of nursing should be in such a plan. With this ultimate objective in mind we have sought certain general information from the provincial associations as to the place nurses have been accorded in the administration of the current provincial health surveys. Replies would

indicate that in nine of the ten provinces nurses have influenced the work of the general survey committees through representation in an advisory or consultative capacity and that in three of these—British Columbia, Nova Scotia, and Saskatchewan—the provincial association was requested to name a representative to the general survey committee. Thus the extent to which nurses can influence the survey findings and subsequent action is limited in consideration of the country as a whole.

Your committee observes further that other matters, already recommended by the C.N.A. Executive, are closely associated with nursing participation in health insurance plans. These include the appointment by the Federal Government of a nurse coordinator of survey findings and a national consultant in nursing. Moreover, we are strongly of the opinion that the national association should take steps forthwith to initiate a survey of nursing throughout Canada by an acceptable and competent person.

In view of the many problems inherent in the growth of professional work, your committee urges the appointment of a qualified public relations officer at our National Office. Such a person could begin with the members of the profession itself, enlarging their concept of nursing and its potentialities in individual, family, community, national and international life, and on through to the general public so that their thought concerning the scope and needs of nursing service and education would begin to be commensurate with the demands made upon the profession.

These and other matters reviewed by the committee are put forward for your consideration in summary form through the recommendations which follow:

1. That the Committee on Health Insurance review the brief presented by the C.N.A. to the Advisory Committee

on Health Insurance in 1943 with a view to outlining what, in their opinion, should be the place of nursing in any future legislation for health insurance—federal or provincial.

2. That whereas the stated policy of the Federal Government is to use the current health grants in order first to survey the need and then to build up services and personnel through which a plan of health insurance could function effectively, your committee supports certain recommendations already made by the Executive Committee:

(a) That there be appointed by the Federal Government a nurse whose function it would be to coordinate those findings of the provincial surveys related to nursing.

(b) That there be appointed by the Federal Government a consultant in nursing.

(c) That whereas returns from the provincial associations indicate that in but nine of the ten provinces has there been nursing representation in an advisory or consultative capacity to provincial survey committees, and that whereas it would appear that in only three of these—British Columbia, Nova Scotia, and Saskatchewan—

have provincial associations been asked to name representatives to the general survey committee, it is recommended that every effort be made by the other seven provincial associations to influence as best they can the findings concerning nursing and their implementation by the survey committees.

3. That growing out of a consideration of the current status of nursing in Canada and with a view to the setting up of machinery which will provide adequate health services for all Canadians, your committee affirms its belief in the basic need of a national survey of nursing as recommended by the Canadian Nurses' Association.

4. That in the meantime renewed emphasis be given the necessity for interpretation of the value of and the need for adequate nursing services to the public as a whole. To this end it is held with conviction that if nursing is to take its rightful place in the life of the nation and if the contribution of the organized profession to that end is to be effective, there be appointed to the staff at our National Office a qualified public relations officer.

FLORENCE H. M. EMORY
Chairman

Arrangements Committee

EACH MEMBER of our committee is busy, thinking and working on many details, which we feel sure will make the coming biennial meeting a really rich, professional experience for all nurses who are fortunate enough to be present. We are planning for a possible attendance of 1,500, so are making sure that there is ample accommodation for every nurse who wishes to take advantage of this educational experience.

The campus of the University of British Columbia is ideal for supplying adequate space for work conferences, exhibits, and all the essential

physical equipment that is necessary for a successful convention.

The general interest sessions are under very able leadership and should prove of practical value to all who choose to observe them. The latest and best in the field of nursing equipment, for both hospital and public health nursing, is being arranged in the way of demonstrations, tours, and films. Private duty nurses are also being carefully considered.

The work conferences will truly prove a democratic experience—the educational challenge and practical assistance gained from this learning

process can well be put to immediate use by all nurses who are fortunate enough to take part.

The social side of the picture is well in hand. Arrangements are being made to fill each evening but the last with some social gathering. We hope one of the highlights will be a navy cruise of Vancouver harbor and adjacent waters, with possibly a picnic supper on board. The alumnae associations of the Victoria, New Westminster, and Vancouver hospitals are being most generous and are sponsoring an evening reception at Stanley Park. This will take place the first evening of the convention.

Likewise, the Vancouver Chapter and Greater Vancouver District Association of the Registered Nurses' Association of British Columbia are sponsoring a coffee hour at Brock Hall on the campus on the second evening. The entertainment committee is planning suitable diversions for both events, to which all members attending the convention are cordially invited. The banquet on Wednesday, June 28, should, indeed, be a gala event; it, too, will take place on the campus.

The overseas nurses are planning a drive and tea on July 1 for all of their members. Their meeting will likely be held on Tuesday evening, June 27.

We are hoping that several of the chapters of the R.N.A.B.C. and various alumnae groups, who have Vancouver branches, will be assisting us by adding that "personal touch,"

which will make this 25th general meeting of the Canadian Nurses' Association something never to be forgotten.

The committee trusts that the various maps that are being made ready for the use of all registering at the convention, as well as our guide and messenger system, will prove a real aid to members. We are endeavoring to secure further information on convenient eating places, trips, amusements, etc., that may be of interest to visiting nurses.

Special accommodation and transportation is being provided for all the religious sisters. We shall have a room set aside for them on the campus where they can rest and relax between sessions.

To add to the happiness of the occasion we are planning some little surprises that we know the visiting members will enjoy and be only too glad to take away as souvenirs. The nurses of the Canadian Pacific West are very proud to have the honor of playing hostess to so great a gathering.

Before I close my report may I thank all the members of my committee who are working so diligently. A very special note of gratitude should go to Sister Columkille, Alice Wright and her excellent staff at the office of the R.N.A.B.C. Without their co-operation, much of our work would have been impossible.

ALISON WYNESS
Chairman

Pediatrics Conference

A three-day conference for nurses is being organized by the Swiss Association of Graduate Nurses (in collaboration with the International Council of Nurses). This Conference will take place in *Zurich* from *July 28-30* inclusive, following the Sixth International Congress of Pediatrics. The emphasis will be on pediatric nursing and, in addition to a program of lectures, opportunity will be given to

visit hospitals as well as to view exhibits and films.

The cost of the Conference will be approximately 100 Swiss francs and to this should be added the cost of travel to and from Zurich. At the present rate of exchange, 100 Swiss francs is the equivalent of approximately £9 sterling or \$25 (American).

For further information write to the **Canadian Nurses' Association, 1411 Crescent St., Montreal 25.**

Committee on Student Nurse Activities

The By-laws of the C.N.A. define the purposes of this committee as follows:

(a) Encourage the organization of Student Nurse Associations in Canada and promote professional interest among Student Nurses.

(b) Endeavor to interpret to students the aims and objects of Professional Nursing Organizations.

(c) Arrange a program of interest to students at General Meetings of the Association.

To date, provincial student nurses' associations are organized and functioning in Manitoba and British Columbia. To stimulate greater interest and enthusiasm among the student nurses in professional activities, a plan for a proposed "Student Nurses' Association of Canada" was submitted to the Executive Committee, C.N.A., in November, 1949. The resolution that such an association be formed was overwhelmingly defeated. The following resolution was passed:

"That the provincial nurses' associations be urged to sponsor the policy of organizing a Student Nurses' Association in each province."

Several of the provincial nurses' associations have given some consideration to this resolution and have reported as follows:

Alberta: The formation of such an association should be brought up for discussion at the annual meeting of the A.A.R.N.

Nova Scotia: The matter has been referred to the branches for discussion and will be brought up at the annual meeting for decision.

Ontario: The Toronto Student Nurses' Association endeavored to evoke interest among the students in other communities with a view to forming a provincial association. Due to a very poor response, it was decided to proceed no further at the present time.

Prince Edward Island: Approved the principle of a student nurses' association organized under the direction of the provincial nurses' association. It was decided to postpone organizing the student nurse body at this time.

No reply has been received from New Brunswick, Quebec, or Saskatchewan.

A work conference for this biennial meeting is scheduled to discuss professional affairs.

In view of the decided opinion favoring provincial control over student nurse activities, the practicability of maintaining a national committee for this purpose is questioned.

MARGARET E. KERR
Convener

Public Relations Committee

The Public Relations Committee has, during the past biennium, attempted to develop a program in the light of its objectives:

1. To foster expanding confidence in what we, as nurses, are doing, by developing a more complete understanding of what we are trying to do.

2. To increase public confidence and understanding of nursing and the nursing profession.

The first step was to recommend the formation of provincial public relations committees. To date, word has been received from British Columbia, Saskatchewan, Ontario, New Brunswick, and Nova Scotia that this has been done. It appears that, in the main, these committees have been studying how a public relations committee might best function and handling some aspects of publicity.

PUBLICITY

Publicity, as one phase of public relations, is the type of activity that a committee can easily start. The news clippings during and since the last convention have indicated that nursing meetings and nursing affairs have news value. Not all the publicity has been desirable but the major portion of it indicates that nursing has a significant role to play in the social developments of the present day. Governments and the general public are increasingly aware of this.

Only a small part of the publicity concerning nursing has been the result of committee action. However, this committee did appoint a press liaison officer in Montreal. Miss M. Burton has given a great deal of time to developing contacts with the press and radio.

Particularly noteworthy was her work at the time delegates were leaving and returning from the International Conference in Sweden. In addition, releases on displaced persons and the Canadian Nurses' Association and Canadian nurses leaving for positions with the World Health Organization, etc., were arranged. Many hundreds of dollars of free publicity has been obtained.

The committee itself has been instrumental in arranging for articles for publication in magazines and the press. The efforts in this direction are being continued but we depend on volunteer authors. Their cooperation is greatly appreciated but the avenues for release far outweigh the material readily available.

National Office staff has spent a great deal of time preparing publicity material. Working with the press liaison officer, providing material for various agencies, such as the Department of National Health and Welfare, revision of pamphlets, etc., are examples. Further plans on the development of recruitment literature and films are under consideration.

The committee has attempted to develop contacts with various publicity resources such as radio. However, the efforts have been, in the main, attempts to counteract adverse publicity rather than take positive action. This points out the impossibility of developing a satisfactory program without sufficient staff to do the detail work. It takes time and skill to prepare articles, scripts, press releases,

RELATIONS WITH OUTSIDE ORGANIZATIONS

Contacts with the Joint Planning Commission of the Canadian Association for Adult Education—with a membership of 85 organizations, 65 strictly national in character—should be invaluable. This provides an opportunity for understanding and interpretation to such organizations as National Citizens Forum, National Farm Radio Forum, Canadian Citizenship Council, Canadian Teachers Federation, etc.

The C.N.A. Executive has approved a recommendation of this committee to the effect that contacts with these organizations be coordinated through a study by the Public Relations Committee of reports presented by representatives of the C.N.A. to other national organizations.

PUBLIC RELATIONS WITHIN THE C.N.A.

It is a matter of some regret that the com-

mittee has been unable to develop a program that would further the first objective of this committee. It is recognized that a large proportion of the activities of the C.N.A. might be defined as Public Relations. However, the committee has reiterated the need for more personnel to further develop some of the activities that would foster improved internal relationships and growth in the understanding and participation of the membership at large.

Much of these first two years of the committee's existence has been spent in trying to find the most effective way to develop its program. It is felt that the solution for some of the problems facing the committee is, to a large extent, outside its terms of reference. It is, therefore, recommended to the C.N.A. Executive that consideration be given to the possibility of having a structure study of the Canadian Nurses' Association undertaken. Such a study should, among other things, give this committee a clearer indication of the needs and resources of the C.N.A. for the development of a sound public relations program in the future.

There is every indication that nurses are being recognized as important to the full development of a national health program. To take their rightful place, each member of the profession must enlarge her concept of nursing and its potentialities in individual, family, community, national and international life. With confidence in ourselves we can push on to the interpretation of the value of and the need for adequate nursing services to the public as a whole. The public expects nursing to adjust to the changes coming very rapidly in this country and in the world. If nurses do not evaluate what they are doing and develop standards and programs suitable for the needs of today, the solution will, by public demand, be found by others.

Are we prepared to leave our future, and the future of the public we serve, to others motivated by expediency? Or are we ready to make a critical analysis of what we are doing, what we want to achieve and, by so doing, set our house in order? If so, then we may take the public into our confidence, assured of their support. On such a basis the Public Relations Committee could work to find the methods by which we may accomplish our objectives.

HELEN G. MCARTHUR
Convener

In the history of the world, there have been ten years of war to every year of peace.

Exchange of Nurses Committee

During the past two years the committee has received three kinds of enquiries: some asked for a straightforward exchange of position; others wished positions in which the educational facilities offered by the committee would be observed; the rest simply asked for employment.

The enquiries resulted in the placement of 16 nurses. A description of the arrangements made for their experience is presented:

Reciprocal exchange: There has been none. However, the committee is pleased to report that proceedings for an exchange are underway between an English and a Canadian public health nurse. Their respective organizations have endorsed the exchange if the requirements of each can be met.

Appointments to positions under the auspices of the committee: A British public health nurse was assigned to the Victorian Order of Nurses (Ontario). A Canadian public health nurse joined the nursing staff of the Queen's Institute of District Nursing (London) and a Chinese nurse was admitted to the staff of the Toronto General Hospital.

Employment: Five nurses obtained positions independently although the initial enquiries came to the committee. Four of the five were British nurses who obtained positions in Canada and one was a Canadian who found

employment in the United Kingdom.

A great deal of the effort of the committee has been unproductive for one reason or another. Some enquiries became applications only to be withdrawn after using the time of the committee and the organizations with which negotiations for positions were proceeding. A true exchange, that is, position for position, seems to be impractical because the demands of apparently similar jobs are different and, therefore, the preparation for them is also.

The opportunity afforded by the committee, has been given little publicity because of the universal shortage of nurses and also because there is an element of "the selection of candidates" attached to the aims of exchange. And, finally, the agreement which candidates have been asked to sign has proved a source of irritation. (It should be noted that such an agreement is not required by the Exchange Committee of the International Council of Nurses.)

It is evident then that, in the light of the experience of the last two years, a review of the aims and functions of the committee is necessary. The review is now in progress.

NORENA S. MACKENZIE
Convener

Committee on Archives

One meeting was held at which time we discussed the scope of the work of archivists and decided that we should interview authorities in the field. Sister Forest approached the record-keepers of the Grey Nuns organization with which she is associated and I interviewed Dr. D. C. Harvey, director of the Nova Scotia Public Archives in Halifax. The following suggestions are now presented for consideration.

For the type of material of interest to the Canadian Nurses' Association a union catalogue is recommended. This catalogue is set up as follows: Any hospital, institution, public health agency, or individual in possession of documents or museum pieces would advise

the C.N.A. and the archivist would then make a card identifying the owner, document, and where kept. This is the system now being initiated by Dr. K. Lamb, director of the National Library Plan.

For documents owned by the Canadian Nurses' Association, a separate file or distinctive-colored card in the union file would identify C.N.A. material. The display of museum pieces or photographs will depend entirely on the physical space available in the office. Some type of filing boxes or folders, rather than paper-wrapped parcels, is recommended for filing. The Public Archives has the box or folder made to order for their various purposes. The important thing is

that it is dust-proof. It was suggested that old and precious documents in handwriting, such as the Florence Nightingale letters, etc., might be photostated in addition to filing the original copy.

The selection of material will be really the most difficult and time-consuming aspect of the archivist's task. There is a distinction made between museum pieces, such as medals, photographs, busts, bricks, etc., and a true archive which, according to the dictionary, is defined as "a record preserved as evidence; or (in plural) records of historical value pertaining to a nation or family."

Thus, records which a school of nursing might rightly consider of historical value to their institution would not necessarily be of historical value to the C.N.A. and thus would not be valid for cataloging in the C.N.A. archives.

It might be feasible for the Canadian Nurses' Association and provincial registered nurses' associations to work out a uniform system of topics under which each provincial association could keep its records and the C.N.A. have an identifying card under the same topic. The interests of the C.N.A. might be divided according to:

A. Education:

1. School of nursing—general, independent, university, curricula, records, personnel policies, residences, etc.
2. Qualifications—various positions, administration, public health, industry.
3. Legislation — international, national, provincial.
4. Scholarships—sources, amounts, where taken, etc.

B. Service:

1. Hospitals—architecture, personnel, administration, etc.
2. Public health agencies—programs, etc.

C. Other:

1. Literature—*The Canadian Nurse*, books by Canadian nurses, etc.
2. Military records
3. Citizenship honors—O.B.E., etc.

Or, division might be made according to type of institution and agency:

1. Schools of nursing—general, university, etc.
2. Departments of Health—federal, provincial, municipal.
3. Voluntary agencies—e.g., Canadian Red Cross Society, V.O.N., etc.
4. Hospitals—general, tuberculosis, mental, special, etc.
5. Professional organizations — I.C.N., C.N.A., R.N.A.'s, C.P.H.A., etc.

Or, yet another approach might be according to activities as represented by the titles of the national committees.

We realize that these suggestions must seem vague but the magnitude of the task overawed us when we discussed it with trained archivists! The points which our advisers emphasized were: the selection of material, simplicity of cataloging, and suitable dust-proof filing of documents in our possession.

E. A. ELECTA MACLENNAN

English Archivist

SISTER JEANNE FOREST, S.G.M.

French Archivist

Quebec Industrial Nurses

At the three-day conference on Industrial Nursing, planned for *May 15, 16 and 17*, to be held at the McGill School for Graduate Nurses and sponsored by McGill University and the Association of Nurses of the Province of Quebec, discussion will centre around topics which have been requested by nurses in industry, concerning such aspects as:

The Role of the Nurse in Industry; The Industrial Nurse and Community Relations; The Relation of the Industrial Nurse to the Workmen's Compensation Board; Interviewing and Counselling; Opportunities in Home Visiting; Visits to Local Industries.

Some of the participants in this program

include: Miss Mildred I. Walker, Senior Nursing Consultant, Industrial Health Division, Department of National Health and Welfare; Dr. K. C. Charron, Chief, Industrial Health Division, Department of National Health and Welfare; Dr. F. J. Tourangeau, Director, Division of Industrial Hygiene, Department of Health, Province of Quebec.

A registration fee of \$8.00 for the entire program, \$1.50 per session, is payable by cheque before *May 8*. Cheques should be made payable to *Miss Ann Peverley (in trust)*. For additional information write to her in care of McGill School for Graduate Nurses, 1266 Pine Ave. W., Montreal 25.

Loan and Bursary Committee

Six loans were granted during the past two years. Members ranging from Alberta to Quebec were the recipients and the amounts involved ranged from \$500 to \$250.

One bursary was awarded. This was for \$250.

The work of the committee has been comparatively light and frequent meetings have not been necessary. This may be explained

by the fact that our policies regarding loans and bursaries are well defined and the qualifications necessary are clearly stated. Then, too, applications have not been too numerous. However, as veterans use up their D.V.A. credits there may be more demands on our funds.

CATHERINE L. TOWNSEND
Convener

The financial statement from May 1, 1948, to February 28, 1950, follows:

Bank Balance as at May 1, 1948..... \$5,566.44

Receipts

Loan Repayments.....	\$3,485.80	
Refund of Government Grant Bursary, credited to loan account. .	205.00	

\$3,690.80

Bank Interest.....	56.31	3,747.11
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\$9,313.55

Disbursements

Loans Granted (6).....	\$2,250.00	
Bursary Granted (1).....	250.00	
Stationery.....	7.84	\$2,507.84

Bank Balance as at February 28, 1950.....		6,805.71
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\$9,313.55

War Memorial Committee

Following the discussions at the 1948 biennial convention, it was decided that the next step in this committee's activity was to secure a capable translator who would translate the explanatory sections of Rothweiler's "Nursing in Pictures" into German. Permission was secured from the publishers, F. A. Davis Co., Philadelphia, to make the translation. Mrs. Marja Sukiennik of Montreal was engaged to do the work which took several months. The Herald Press Limited generously printed and bound the book at a very special price of \$1.00 per copy when its purpose, and the auspices under which it was being sponsored, was explained to them.

Nineteen hundred copies of the German translation and 100 copies of the English volume were sent to Germany; 720 copies of the German and 20 copies of the English book were sent to Austria. Receipt of the latter has not been acknowledged. The letter from Schwester Ruth Schramm, executive secretary of the German Nurses' Association, indicates the sincerity of their gratitude. She says, in part: "In the name of the Nurses of the Deutsche Schwesterngemeinschaft, I want to tell you our very heartily thank for this enormous large present that the Canadian Nurses gave to us German Nurses. We are delighted of the book and find the whole

idea of you splendid . . . The students will be enchanted to learn after this very good scheme of yours . . . I beg you once more to tell all the Canadian nurses how very thankful we are."

It will be recalled that, beginning in August, 1946, some 50 subscriptions to *The Canadian Nurse* were sent to nursing leaders in various war-torn countries. The committee deemed the extension of this plan, to include a number of the schools of nursing in these countries, would bring up-to-date information regarding nursing practice to the nurses more regularly than additional nursing texts. Moreover, it would serve to inform the nurses of the activities of the Canadian Nurses' Association. Letters were sent to a dozen countries asking for lists of prominent schools. Four-year subscriptions were purchased for 172 individual nurses and schools of nursing.

Several requests have been received from

schools of nursing in France and Italy for a variety of textbooks in the French language. Fortunately many of these are readily available and have been shipped.

The committee was authorized by the Executive Committee to send wall charts as teaching aids to many of the schools of nursing. As this report is written, negotiations are underway with the Denoyer-Geppert Co. of Chicago to supply some \$10,000 worth of a very fine set of anatomical charts to be shipped by them at our direction.

The bank balance for this special fund at January 23, 1950, was \$16,145.43. After the wall charts are paid for, it is proposed to spend the balance of the fund on additional texts which will be sent, together with the used books now on hand, to various countries.

MARGARET E. KERR
Convener

In the Good Old Days

(*The Canadian Nurse*, May 1910)

"Judging from the little I could find written on the subject of noise in hospitals, I think it is one that has been neglected both in theory and practice. Have you not heard the slamming of the door, the doctor's stentorian 'good morning,' the stumbling of the visitor as he slowly mounts the stair, the laughing chatter of some idiotic house surgeon or sillier nurse, the moaning of the operative, the crying of children, the whistling of the staff, and the thousand other noises which may be within our walls?"

* * *

"The medical and surgical wards should be separated from each other. A recovery room will be necessary off each surgical ward in order that convalescents and others may not be subjected to the depressing influence of the post-operative patient recovering from chloroform."

* * *

"Seventy-three hospitals have received government aid in Ontario and not one of them has closed its doors. After the first year or two of operation, I have never heard any place regret the establishment of a hospital.

Hospitals are here to stay. All progressive centres must have them. The government grant is 20 cents per patient per day for the first ten years, so that if all your 12 beds are occupied all the year you would get about \$800."

* * *

"The Sisters of the Hotel Dieu in Montreal are considering the building of a new hospital under English-speaking management. It will cost about \$100,000 and a site has already been offered to the Sisters."

* * *

"An Act to incorporate the Nova Scotia Graduate Nurses' Association, introduced before the Legislative Assembly, has been approved by the Bills Committee and passed."

* * *

"The Nova Scotia Hospital at Dartmouth was the second institution in Canada to establish a training school for nurses in connection with the care of the insane."

Tin was the first metal used by man.

Provincial Association Highlights

While this issue is devoted largely to the reports of national committees, no such record would be complete without a summary of how the federated bodies that compose the C.N.A.—the provincial nurses' associations—are dealing locally with the various developments that are the true picture of nursing activity today. Rather than publish each provincial report separately this compilation will show how certain trends are common to all parts of our country. There are some differences also which are noted.

Legislative action: The provincial acts under which the associations function are a vital part of the nursing picture. New Brunswick's nursing act was revised in 1949. Prince Edward Island nurses petitioned for a licensing act which came into effect on January 1, 1950. Alberta nurses amended their by-laws to provide for two types of non-practising membership—associate and inactive. Over 1,700 nurses responded to the letters, 891 of whom held associate membership last year. Manitoba and Nova Scotia have studied their present act, constitution and by-laws, preparatory to redrafting them. Ontario nurses were unable to secure legislative presentation of their proposed bill. The association is endeavoring to find an approach that will meet with governmental approval without compromising the objectives of the association. Ontario has also made provision for associate memberships in its by-laws.

Legal assistance: The R.N.A.O. is the first to make provision for legal service to its members. Through their provincial office, members have access to legal advice in connection with any matter arising out of the practice of nursing. The association does not undertake the active conduct of legal action, nor does it undertake to pay costs or damages arising out of litigation but the official solicitor will advise on request.

Registration: British Columbia continues to attract a very large number

of nurses from every province and many countries. There were 409 applications for reciprocal registration granted in 1949. B.C. is experimenting with the registration examinations set and graded by the National League of Nursing Education with gratifying results. In Quebec, applications for licensing under the waiver clause of the Licence Act terminated December 31, 1948. Special classes have been arranged in Quebec to enable nurses, who entered Canada as displaced persons, to qualify for their registration examinations. The Saskatchewan regulations require that "all graduate nurses on a hospital staff shall be registered under the Registered Nurses' Act and be members in good standing of the S.R.N.A."

Both New Brunswick and Prince Edward Island have plans for the institution of qualifying examinations at the end of the first year of training. This program is already functioning in most of the provinces.

Curriculum revision: British Columbia, Manitoba, Quebec, New Brunswick, and Prince Edward Island have had committees at work drawing up or revising the minimum curriculum for schools of nursing. Quebec reports that no minimum has yet been established.

Affiliation programs: Several new developments have taken place during this biennium. Courses in tuberculosis nursing have now been made available for a limited number of student nurses in Alberta and Saskatchewan. An affiliation program is also operating in psychiatric nursing in those two provinces. Saskatchewan has a new development, too, whereby some students have an opportunity of receiving supervised experience in small rural hospitals.

Dominion-Provincial Youth Grants: These are available to student nurses in most provinces. Ontario tried unsuccessfully in 1948 to secure this form of assistance.

Personnel practices: Several prov-

inces have had an approved schedule for salaries, hours of work, sick leave, vacation, etc., as applied to graduate staffs for some years. Ontario has drafted a report, embodying recommendations regarding these measures for presentation to their annual meeting this year. New Brunswick recently set up a committee to draw up personnel policies for student nurses.

School visitor: Alberta has had the appointment of such an officer under consideration for some time. As soon as a suitable person can be found to undertake the work, an appointment will be made there. New Brunswick and Prince Edward Island have agreed on the feasibility of making a joint appointment. The matter is still pending in Nova Scotia.

Refresher courses: With a view to keeping their members fully informed on new trends and techniques, every provincial association has conducted one or more institutes during this biennium. Nursing forums have been developed in a few isolated localities.

News bulletins: Some means of communicating directly with individual members is in effect in most of the provinces. Quebec launched a semi-annual bulletin in 1949. Alberta nurses approved the use of paid advertising as a means of defraying bulletin publication costs.

Auxiliary personnel: Courses are approved in most of the provinces for the training of auxiliary workers under the Canadian Vocational Training plan. Nova Scotia has decided to defer approval of such training until some satisfactory means is provided for regulating the standards and practices of such practical nurses. Prince Edward Island reports the auxiliary personnel are interested themselves in securing licence legislation.

Nursing surveys: These have been or are in process of being made in several of the provinces. Nurse representation on the Health Survey Boards was requested by the nurses' associations and in most provinces was granted. Saskatchewan reports that a cost analysis of nursing education versus nursing service has been under-

taken in two schools of nursing. No data have been released yet. The Saskatchewan nurses are also represented on a provincial sub-committee on hospital construction.

Miscellany: British Columbia secured the approval of the College of Physicians and Surgeons for a course for registered nurses in the *administration of intravenous medications*. After a special committee of three doctors had drawn up a list of drugs which could be administered by nurses with safety, a special committee prepared a course outline which has been approved by the R.N.A.B.C. The course will soon be available to selected nurses.

The *industrial nurses* of Ontario have organized as a separate committee within the framework of the R.N.A.O. and will receive a grant from the association similar to that now given the other special interest committees.

Special disability insurance has been made available to the members of the nursing associations in Ontario and Quebec. The premium cost is 30 to 50 per cent below the rate of ordinary individual plans. The plan provides income protection to the extent of \$75 a month for one year in cases of disability from sickness or accident. It covers pre-existing conditions and has no exceptions to coverage except suicide, maternity, and military service.

New *provincial executive secretaries* have been appointed in several provinces during the biennium. Alberta, Ontario, Prince Edward Island, and Quebec have installed new officers following the resignation or retirement of former personnel. Saskatchewan has appointed an assistant registrar.

Christian Fellowship

Congratulations to the newly-formed Vancouver Graduate Nurses' Christian Fellowship. A similar group has recently been formed in Victoria, meeting every other Friday at the home of Miss Nancy Wright, 2095 Oak Bay Ave., Victoria, B.C. Visiting graduates are invited to contact us at this address by phoning Garden 4945.

Nursing Profiles

Marion Lindeburgh, O.B.E., one of the outstanding leaders of nursing in Canada, on May 12 will receive the degree of Doctor of Science (*honoris causa*) at the annual convocation and graduation exercises of the University of British Columbia, Vancouver.

The heritage of an Irish mother and a Danish father mingle in Miss Lindeburgh. Born in rural Saskatchewan, life was not easy but it held no insurmountable barriers for the girl who, while still in her teens, completed her normal school training in Regina and commenced her long career as a successful teacher. In a spirit of gay adventure, Miss Lindeburgh spent 12 years enlightening the youth of Saskatchewan in rural and urban schools. Nothing was too much trouble—whether it was functioning as her own janitor, even to shovelling snow, or organizing Christmas parties and concerts for her school children.

During World War I, the urge to become a nurse seized Miss Lindeburgh. Not content to enter just any school of nursing, she weighed the facilities offered by many. Her choice was for St. Luke's Hospital School of Nursing, New York. Following graduation in 1919, she worked there successively as head nurse, clinical supervisor, and night superintendent.

Her pioneering spirit would not let Miss Lindeburgh linger for more than three years in the relative security of a large urban hospital. In 1922 she returned to her native

province and travelled far, teaching the principles of good health to the children of the rural schools. Her skill and enthusiasm soon won a place for her as instructor of health education at the Regina Normal School. She set a high standard of health knowledge and attitudes among these embryo teachers which is still reflected in the excellence of Saskatchewan's health program.

In 1929 a new challenge faced the alert mind and iron will of Miss Lindeburgh. She accepted the position of assistant to the director of the McGill School for Graduate Nurses. Shortly after, when the rigors of the depression threatened the very existence of the School, Miss Lindeburgh moved up into the directorship. Her organizing ability was put to a severe test in the years that followed as she sought and won the cooperation of the graduates of the School in providing the financial support needed to keep the School in operation. Her dynamic personality overcame countless threats to the School's stability. Its standing today as an integral part of this ancient university is due to Miss Lindeburgh's unquenchable faith in the School's destiny.

As if that were not enough effort for one mere mortal, Miss Lindeburgh spent many of her summer vacations during the '30's in study at Teachers College, Columbia University. She received both her bachelor's and master's degrees during this time. Even this activity did not occupy all her energies. In 1934 she became chairman of the Nursing Education Committee of the Canadian Nurses' Association and for eight years skilfully directed the studies which culminated in the imposing tome "The Proposed Curriculum for Schools of Nursing in Canada" and, later, the "Supplement to the Curriculum."

In 1938, Miss Lindeburgh assumed the office of second vice-president of the Canadian Nurses' Association. The hectic pressures of the busy days during World War II brought many problems to her tenure of the C.N.A. presidency from 1942 to 1944. During this period, in 1943, her distinguished service to Canada was recognized when she received the award of Officer of the Order of the British Empire from His Majesty. The Canadian Nurses' Association presented her with its



Notman, Montreal

MARION LINDEBURGH

highest award—the Mary Agnes Snively Medal—in 1944, in recognition of her sterling professional contributions.

Life is not all a round of work to Marion Lindeburgh. The hundreds of students who have shared the friendly hospitality of her home know well how she loves to cook and bake. She has found time for relaxation in quaint, obscure spots where she hiked, cycled, and swam her way to vigor. Her generosity, her kindness and thoughtfulness have endeared her to countless persons who treasure the thought that “Miss Lindeburgh is my friend.”

Grace E. Johnson is director of nurses at the new Maternity Pavilion of the Winnipeg General Hospital. Born in Manitoba, Miss Johnson graduated from W.G.H. in 1933. She was a head nurse in the maternity department from 1934 until her enlistment with the R.C.A.M.C. in 1940. She served as a nursing sister in Canada and England with the neurological and plastic surgery units. Following her discharge, Miss Johnson was assistant superintendent of nurses at W.G.H. for a year before enrolling with the McGill School for Graduate Nurses. There she secured her Bachelor of Nursing degree in 1949, majoring in administration in schools of nursing.

Helen Jean Lynds, who is the superintendent of the Miramichi Hospital, Newcastle, N.B., has had an interesting variety of experiences. Graduating in 1924 from the Calgary General Hospital, she engaged in private nursing in centres in Alberta and New Brunswick for three years. In 1929 she joined the staff of the Saint John Tuberculosis Hospital, followed by a couple of years at Dobbs Ferry, N.Y. She returned to private duty in Calgary in 1933. Five years later she joined the group of Canadian nurses who went to South Africa. For a year she was a staff nurse on the dermatological ward of Groote Schuur Hospital. In 1939 she became night supervisor at the Somerset Hospital in Cape Town shortly after it was opened as the first training school for colored girls. She returned to Canada late in 1945.

Beatrice Mary Hadrill, who retired from the superintendency of Miramichi Hospital,

*Van Dyck***GRACE JOHNSON**

Newcastle, N.B., last year, received her Arts degree from McGill University in 1912. Graduating from the Montreal General Hospital in 1917, Miss Hadrill has had a varied career in many branches of nursing—general duty, private duty, industrial, orthopedic supervisor, teacher, superintendent. She enrolled with the McGill School for Graduate Nurses and received her certificate in teaching and supervision in 1931.

Miss Hadrill has returned to her native province of Quebec and has built herself a home, modelled on her own plans, at St. Andrews East, where her many friends are certain of a warm welcome.

**HELEN LYNDS**

The longest words in the English translation of the Bible are “commandments” and “testimonies.”

Public Health Nursing

Strengthening the Home Visit

SYRETHA MILLEY

Average reading time — 2 min. 48 sec.

A QUESTION that keeps recurring, and is indeed uppermost in the minds of many public health nurses, is "*Why do patients with tuberculosis act as they do?*" We are sad and provoked when a clinic appointment is not kept. We go over and over our visits with these patients, trying to find out where we failed to establish a rapport.

This same question evidently troubles the American nurses as well, for in the December, 1948, issue of *Public Health Nursing* there is an editorial called "Tuberculosis Control: A Challenge to Nurses," in which the same question is asked:

Why do T.B. patients act as they do?

How can we come to understand them, help them, and motivate them more effectively? No professional person is closer to these patients than is the nurse. No one group can concern itself with this aspect of the problem to better purpose than the nursing group . . . Tuberculosis, so old and still so much with us, offers a fertile ground for research in which the last few years have been especially rich—the value of streptomycin; world-wide studies of B.C.G. protective vaccine are in progress.

Then the editor makes the most important statement for nurses when she says: "A great area for research in the field of *interpersonal relations* is still untouched."

As students in public health nursing at the university, we were given very full and comprehensive notes. They are valuable today and are here appended in the hope that, by

thoroughly digesting them, we may be able to answer the many questions that bother us, when we have not succeeded in selling the urgency of tuberculosis control to a patient and his family. "Nurses must assume their place in tuberculosis control and this place must be among the *leaders, planners, and doers*. The world-wide program depends on us. The challenge is great; let us be determined we shall meet that challenge."

Prepare for the visit by study of whole family: Know thoroughly previous problems and contacts. Consider the whole family instead of individual problem. Summarize and make notes on family needs.

Make a friendly, cordial, informal approach: Use commendation generously. Avoid a critical, dictatorial attitude.

Adapt content and method to situation: Teach simply, reinforcing by repetition if necessary. Use literature in connection with explanations. Demonstrate procedures. Leave important directions in writing.

Watch for opportunities to cooperate with other agencies: Encourage family to assume its own responsibilities. Determine assistance needed according to situation. Give full information to assisting agency.

Keep a complete record as basis for future work: Describe situation. State constructive work done or advice given. Indicate further needs.

Evaluate visit as means of professional growth: Was family regarded as unit? Was contact friendly and constructive? Was response favorable? Was social co-operation furthered?

Mrs. Milley is a public health nurse with the Stormont-Dundas and Glengarry Health Unit, Cornwall, Ont.

Butterflies taste with their feet (originally called "flutterbys").

Institutional Nursing

The Paraplegic Patient

E. McKEAN

Average reading time—8 min. 6 sec.

FOREWORD

The nursing of "paraplegics" has not changed to the individual patient but the overall concept has. The change is due to war experience—for example, the United States Army had just over 1,500 paraplegic war veterans. For the first time there was a large number of paraplegics who lived, due to better medical services, and from this evolved the rehabilitation of a paraplegic, and thus our whole treatment is aimed at putting a paraplegic person back into gainful employment.

It was found that having all paraplegics together from the beginning led to much improved morale and, from then on, they demanded the best that medicine and nursing could give them. No longer were they the forgotten men in the corners of the accident wards where the nurses kept them alive. It became a team job and in the case of the Vancouver General Hospital Paraplegic Service every department of the hospital has been consulted—even the administration, who had to approve the cost of the extra diet and the

fire regulations for unusual ward equipment.

The specialties of genito-urinary and plastic surgery have probably added most to the surgical recovery of the paraplegic, but it is team-work that gives the best end-results—where the nurses are enthusiastic and relay the small signs and symptoms to the doctor in charge, while he, in turn, conducts a daily ward round, picks and chooses the specialists required for the individual, and keeps the patient on the upgrade all the time. The dramatics of the closing of a large decubitus ulcer are as naught if the patient has not been hounded for weeks to eat and the doctor has not seen that the serum protein and hemoglobin, etc., are adequate to undergo the operation.

It is because of the appreciation of the enthusiasm of the nurses of our "paraplegic" service that it gives me much pleasure to write a foreword to Mrs. McKean's article.

Dr. W. A. MORTON,

Physician in Charge of Paraplegic Ward

The care and treatment of paraplegic patients as a group was started at the Vancouver General Hospital in February, 1947. The average number of these patients on the ward has been about 20. The majority of the patients are between the ages of 20 and 30, mostly males. Their stay in hospital usually has been 9 to 12 months. The staff consists of 3 graduate nurses, 4 orderlies, 13 nurse aides, and one practical nurse student. Rehabilitation is stressed from the

beginning of the treatment. Dr. W. A. Morton is in charge of the paraplegic patients and takes a great interest in their treatment and in every aspect of rehabilitation. Much time is spent by the Social Service Department and by members of the Workmen's Compensation Board in planning for rehabilitation, which means frequent visits to the patients.

A "walking school" is conducted in the Department of Physical Medicine by Mr. Martin Berry, chief instructor of the Canadian School of Physical Re-education in Vancouver. The staff of this school also gives daily instruction on the ward.

Mrs. McKean is head nurse on the ward for paraplegic patients at the Vancouver General Hospital.

All the doctors have taken a special interest in teaching the orderlies to take care of these patients, to give daily saline baths, to dress decubitus ulcers, and to do catheterizations and tidal drainage, etc. General nursing care, dressings, and medications are carried out by graduate nurses and nurse aides. All genitourinary work is checked regularly by a member of the visiting staff. This is a real and constant problem with the paraplegic patient. Members of the visiting and consultant medical staff of the hospital are called for consultation.

Routine on admission: A patient with fractured spine is usually kept in bed three to four months and then, if the x-ray is satisfactory, he is allowed up in a wheel-chair and to the bath. While in bed, he will have had daily instruction in remedial exercises for the arms. His special treatment includes:

1. High caloric diet with added protein such as essamine or protonol in drinks.
2. Weekly urinalysis.
3. Enema every second day until the patient is getting up and then simple suppositories daily in place of enema.
4. Supplivites—2 t.i.d. It is noticeable how few medications are required.
5. Patients are allowed rubbing alcohol at the bedside and are encouraged to rub their own hips.
6. Tidal drainage with the Foley catheter is started to encourage an automatic bladder. This is not always entirely successful but it helps to counteract the formation of stones in the urinary tract. Acetic acid solution $\frac{1}{2}\%$ is used for this. It is imperative that the catheter be removed and tubing taken apart, cleaned, and sterilized every week.

ROUTINE EXAMINATIONS

1. X-ray of the spine will show the level of the lesion and the progress of healing.
2. Intravenous pyelogram to check for stones of bladder or kidneys. In many instances these have been found and removed.
3. Blood count.

COMPLICATIONS

1. The greatest danger is pressure

sores. These can develop very quickly on account of nerve injury. Patients with pressure sores have been brought from long distances to be treated by skin graft.

2. Bladder infection and renal calculi.

3. Dropped feet will develop quickly if feet are not protected by foot-board and kept in good position.

TREATMENT OF PRESSURE SORES

1. Saline tub-baths daily.
2. Cleansing with Dakin's dressings or pyruvic acid jelly.
3. Rotation flap or skin graft.

ROUTINE FOLLOWED FOR OPERATION

Rotation flap for decubitus ulcers:

A. Pre-operative care

1. Hemoglobin check and if below 70% blood transfusions are given.
2. Sulfasuxadine for 3 days preoperatively, starting with Tab. ii q.i.d.; Tab. iii the 2nd day; and Tab. iii the 3rd day. This is to combat *E.coli* infection to the skin graft area.
3. S.S. enema on the evening before the operation.
4. The usual sterile preparation, preparing plenty of skin for graft from back of the thigh.

B. Post-operative care

At the time of operation a small catheter, No. 12, is sutured into the flap area and, on return to the ward, streptomycin, 100,000 units, is instilled into it and continued b.i.d. for 3 or 4 days. The catheter is removed at the first dressing. Vaseline mesh is used for dressings and changed as often as necessary—about every 2 days.

Sulfasuxadine Tab. ii q.i.d. continued for 10 days, when sutures are removed and saline tub-bath is given. At this time the dressing from the donor-area is soaked off.

Post-operatively, the patient lies on his face most of the time until the sutures have been removed. An enema is given on the 3rd day before the first dressing. In two weeks, the patient should be ready to resume exercises.

The ward: It has been equipped especially for these patients. The baths and toilets are fitted with overhead handles and side-bars on the walls. Doors are replaced by curtains to make it easier for wheel-

chairs to get close to the bath. Mirrors are lowered to wheel-chair level for shaving. Each patient has his own wheel-chair and, when ready to walk on crutches, steel braces are made for him.

Rehabilitation program: This is started on the ward and stressed from the beginning of the treatment. It includes:

1. Mat work daily, which includes muscle education, weight-lifting. In winter this is done in a room set aside for the purpose and, in summer, on the sun-roof. Ball games are included.

2. Walking school is attended three days a week at the Berry School in the Department of Physical Medicine, where two-point crutch walking is taught in front of a mirror.

3. Occupational therapy: This department is under the supervision of Physical Medicine, with a full-time occupational therapist and a workshop on the ward. The patients make and sell slippers, purses, albums, and other articles.

4. Some patients are studying for high school and accounting examinations under supervision of a teacher.

For amusement, up-patients are allowed out for drives and shows twice weekly.

On discharge, the patient is ready for direct rehabilitation. Before he leaves hospital, he is able to take his own bath and enema. He learns to walk up or down stairs on crutches

and, if he falls, to pick himself up. He also learns to get in and out of a car by himself. Working in a group, the paraplegic patients are cheerful, cooperative, and encouraging to one another.

The greatest problem to the patient on discharge from hospital is bladder control. If there is not good control, the male patient can wear a rubber urinal which is satisfactory. With the female patient, the rubber pants seem to be the only solution.

During the past year, many patients have been rehabilitated to gainful occupations, for example:

1. A man of 25 is now working in an office eight hours a day and drives his own car.

2. A man of 21 is despatching in the office of a messenger service. He also drives his own car.

3. A man of 24 is working at book-keeping in a printing office.

4. A man of 20 is working in a shoe repairing shop.

5. Two married men about 50 years of age are now established at home and are able to take care of themselves, after seven or eight years in hospital.

6. A man of 25 is despatching for two companies which have arranged to have two telephones in one office.

Many of these patients return for check-up after several months and are encouraged to report to their doctors at regular intervals.

Compensation Assured

All hospital or sanatoria employees in Ontario, including nurses, are now assured of compensation should they contract tuberculosis through contact with patients. In making the announcement, Premier Frost revealed that the entire cost of this extra protection would be assumed by the province.

The matter has been under consideration by the Government for a couple of years. The Compensation Board was asked to provide an estimate of the cost of the new plan. The Board figured out that the assessment now paid by the hospitals would have to be increased from 50 cents per \$100 of payroll to \$1.50 unless the province decided to pay the extra assessment. The Government estimated that it was too much of a burden to impose on the hospitals and that, on

the other hand, the personnel of the hospital and of the sanatoria were entitled to such protection on account of the vital service they were performing. With a system of compulsory x-ray of patients being instituted as quickly as the necessary equipment can be obtained, the danger to nurses and other employees will be reduced and cost of protection will decrease. The program will cost approximately \$200,000 a year for the present.

All employees with more than three months' service will be covered immediately. New employees will have to wait three months before they are protected. However, they will be protected for three months after they leave the hospital's service.

—Ontario Government Services

Private Duty Nursing

Tetanus

BETTY RUTHERFORD

Average reading time — 4 min. 12 sec.

THOUGH infrequently encountered in modern practice, tetanus presents grave problems to the physician and nurse, despite recent advances in its treatment. Its rareness may be judged from its incidence in B.C.—out of a population of approximately one million, only three cases were reported in each of the previous two years. This is in strong contrast to the wide distribution in nature of the causative organism *B. tetanus*.

This disease is characterized by violent muscular convulsions caused by the action on the nervous system of a toxin elaborated by this bacillus. If untreated this condition may result in death due to exhaustion or by interference with respiration. The organism gains entrance to the body through a wound, especially if the latter involves extensive death of tissue or is of the deep-puncture variety. The presence of oxygen inhibits the multiplication of the organism and toxin production and it is thought that this factor is partly responsible for the rareness of the disease. The other factor is the widespread administration of prophylactic antiserum at the time of the injury.

By coincidence two cases of tetanus were admitted to this hospital within three weeks of each other. The first case was a middle-aged woman seen in the late stages of the disease. Despite the administration of antiserum she died within 24 hours. The second case is presented below:

John, a boy of 13, fell and cut his left leg below the knee. Nine days later he was admitted to hospital complaining of

tightness of the jaws and pain in his back and neck. His mother stated that for three or four days previously he had been staying around home, and kept wanting to sit on her knee, which was most unusual. John stated that he stayed home because he had nothing else to do.

Two nights before admission he noticed some tightness at the back of his neck. The day before admission he had difficulty in holding his head erect and stated "it was as if my head was too heavy for my body." He experienced some difficulty in swallowing his breakfast. Attending the movies that afternoon he returned home feeling worse and a little stiff. That night he noticed the tightness of the jaws. He awakened the day of admission at 4:00 a.m. with pain in his back and neck, with difficulty in moving his head, and also some pain in the front of his chest.

On admission at midday John was unable to lie on his back and there was moderate spasm of his back muscles with twitching of his hamstrings. He was conscious, rational, and exhibited trismus. He had already correctly diagnosed his condition as lockjaw.

Immediate treatment with large doses of tetanus antiserum was started—160,000 units by intravenous and intramuscular injection. In 83 hours John received 260,000 units which was the total amount given. Penicillin therapy was started with a first dose of 500,000 units and 100,000 units every three hours. This was gradually reduced and stopped on the 17th day with a total dose of 9.7 mega units. Intermittent intravenous injections of a d-tubocurarine were also given, to relax the muscle spasms, in doses of 4 to 7.5 mg. approximately every hour as the condition indicated. The total administration was 226 mg.

Miss Rutherford is a 1949 graduate of St. Joseph's Nursing School, Victoria, B.C.

Sedatives were prescribed in the form of nembutal to be given when necessary. During his stay he received 88 gr. together with 9 gr. of phenobarb.

The 4th day following admission, Myanesin, a spinal cord depressant, was started by mouth in doses of .5 oz. of the elixir in water every three hours. Difficulty was encountered in the oral administration since it was so unpalatable. On the 5th day a Levin tube was inserted. John received a total of 39 oz. of the elixir by the tube which was stopped on the 13th day. Twenty-four hour feedings, containing 3,500 calories per day, were also started and given by this method.

A week after admission John started slowly to improve. After hospitalization for a month he was discharged. His condition was satisfactory except for a general systemic weakness and a slight residual tightness of the jaws.

On the second day of admission

the dressing taken from the wound was sent to the laboratory. No growth was reported. From a swab taken a week later there was a similar report.

The nursing care consisted primarily of placing the patient in a quiet darkened room. All noises or vibrations were prevented because they served to stimulate spasms. In the hospital all traffic was directed away from the ward in which John was placed. Someone had to constantly be with him, so from the time of admission until discharge special nurses were necessary.

In no condition is the constant and immediate attention of a competent physician and, at the same time, good nursing care more important. This makes the difference between life and death. The antitoxin which opposes the poison must be given early in the disease and in large doses if it is to help the patient and prevent death.

In Memoriam

Marion Eileen Abey, who graduated from Moose Jaw General Hospital in 1927, died suddenly on February 22, 1950, in Vancouver. Miss Abey had been on the staff of Shaughnessy Hospital since 1946.

* * *

Margaret (Castell) Anderson, who graduated from the Vancouver General Hospital in 1933, died at Powell River, B.C.

* * *

Ivy Irene Buscombe, who graduated from the Hamilton General Hospital in 1921, died in Hamilton on December 10, 1949, following a lengthy illness. Miss Buscombe served for some 23 years as head nurse and clinical instructor in her own school of nursing where she will always be remembered for her graciousness and sterling character. She retired two years ago.

* * *

Grace J. Firth, who graduated from the Montreal General Hospital in 1912, died in Toronto on February 28, 1950. Miss Smith spent some years in the Woman's Missionary Society Hospital in Matheson, Ont.

* * *

Frances M. (Clements) Hamilton, who graduated from the Royal Victoria Hospital,

Montreal, with the first class in 1896, died in Montreal on January 25, 1950.

* * *

Jean (Roberts) Hendry, a graduate of the Owen Sound General and Marine Hospital, died recently in Victoria, B.C.

* * *

Muriel (Pickup) Schonberg, who came to Canada from England some 15 years ago, died in Brandon, Man., in January, 1950. Mrs. Schonberg had been engaged in public health nursing in Brandon until the time of her illness.

* * *

Elizabeth (Monteith) Shillinglaw, one of the earliest graduates of the Brandon General Hospital and matron there from 1896 to 1898, died on February 11, 1950, after a lengthy illness, at the age of 85. Mrs. Shillinglaw was honorary president of the Brandon Association of Graduate Nurses.

* * *

Mary Smith, who graduated from the Lady Stanley Institute for the Training of Nurses, Ottawa, in 1895, died at her home in Almonte, Ont., on January 19, 1950, in her 89th year. Miss Smith was a pioneer in private duty nursing in the Ottawa Valley.

Aux Infirmières Canadiennes-Françaises

Le Travail d'Équipe en Nursing

OCTAVIE PRÉFONTAINE

Average reading time — 15 min. 48 sec.

L'EXPRESSION "travail d'équipe" est une des plus souvent employées dans le vocabulaire de personnes intéressées ou s'occupant du travail d'organisation et d'administration des services de santé. De nombreuses attestations du besoin du "travail d'équipe" sont démontrées dans les revues scientifiques, les articles populaires, les lois et règlements administratifs, et dans les procédures de conférences, se rapportant aux programmes de santé, fonctionnant sous les auspices d'agences publiques ou privées.

Le dictionnaire définit le "travail d'équipe" comme: "Travail fait par un groupe de personnes associées, solidaires les unes des autres, et visant à l'objectif le plus élevé, pour le bien de tous." De plus, en vue d'un "travail d'équipe," la coordination peut être définie par "une coopération bien dirigée" ou mieux encore "une coopération automatiquement établie." Il devient évident qu'une telle coordination ne peut résulter, que d'un "travail d'équipe" efficace, qui, en retour, fait appel à une discipline ponctuelle de personnes, qui déjà ont la juste attitude d'esprit. La coopération naît d'une attitude qui, comme les autres, est le fruit de connaissances et d'habitudes acquises, qui sont le résultat d'une formation et d'une orientation, auxquelles on a dû se soumettre.

OBJECTIFS

Les nombreux objectifs à atteindre par le "travail d'équipe" dans un service de santé peuvent être les suivants:

1. Aider l'individu à se maintenir bien portant, physiquement, et mentalement; et à mener une vie personnellement satisfaite et utile à la société.
2. Diagnostiquer et traiter aussitôt que possible, d'une manière complète et compétente, toutes les conditions anormales de la santé de l'individu; puis mettre en évidence, et inclure dans le plan de traitement, tous les facteurs émotionnels et socio-économiques ayant une répercussion sur la condition anormale de la santé.
3. Aider tous les membres des diverses professions affiliées; ainsi que le personnel des cliniques et des hôpitaux à réaliser un service de santé adéquat, en tant que qualité et quantité, pour l'individu malade ou en santé; faire promptement le rapportage des cas; respecter l'intérêt et apprécier le travail de chacun.
4. Aider les agences officielles et volontaires à bien s'organiser pour l'établissement des facilités nécessaires et des plans de service pour le public.
5. Aider les agences gouvernementales et autres, administrant les programmes de santé, à répartir leurs fonctions avec économie et efficacité, considérant la qualité, la consistance, et la continuité du service.
6. Fournir au citoyen l'occasion de contribuer, par sa participation, dans l'initiation et l'administration des programmes de santé publique; et lui en assurer le contrôle démocratique.

Mlle Préfontaine est surintendante du service d'infirmières visiteuses, Cie Metropolitan Life Insurance, Montréal.

PROCÉDURES

Toute entreprise coopérative amène le problème des relations entre travailleurs de même intérêt professionnel; d'ordinaire ces relations ne sont plus un problème, dès que les intéressés se sont réunis pour discuter leur plan d'organisation. Les entrevues privées et les réunions de groupe sont les meilleurs moyens, pour se rendre compte, comment on peut travailler ensemble; cette formule n'est pas nouvelle mais son application peut être développée et améliorée suivant le besoin.

Le plan de "travail d'équipe" montré ici indique comment on a procédé dans l'organisation d'un programme, en vue d'améliorer les soins à donner à des cas de colostomie; ce même plan peut également s'adapter à d'autres patients. L'objectif à atteindre est de fournir au patient une rassurance psychologique, ainsi qu'une assistance pratique dans un moment très difficile de sa vie. Ce programme comprend la période préopératoire et se termine quand le patient peut dépendre de lui-même, et qu'il est réhabilité à son foyer d'une façon satisfaisante parmi les membres de sa famille et ses amis.

Pour réaliser ce plan, un comité actif fut formé de représentants de divers services, qui directement ou indirectement avaient une influence sur les soins à donner aux patients; les membres se composaient du chirurgien, de l'infirmière en charge du département médical et de chirurgie, d'infirmières graduées, du personnel, d'une travailleuse sociale, etc.; puis un sous-comité, comprenant des infirmières de différents services.

FONCTIONNEMENT DE CE "TRAVAIL D'ÉQUIPE" DANS LES PROCÉDURES DES SOINS À DONNER À UN CAS DE COLOSTOMIE

SOINS À DONNER AU PATIENT MANIÈRE D'ADMINISTRER LES SOINS

Phase I
Période préopératoire quand l'opération est projetée et qu'il y a possibilité de pratiquer une colostomie.

Renseignements à donner au patient et à sa famille, en ce qui concerne une colostomie. Nécessité de pratiquer l'opération.

Accentuer sur le fonctionnement normal de l'organisme; et sur le grand nombre de personnes qui ont subi la même opération.

Assurer le patient que les infirmières donneront les soins et les instructions nécessaires durant la période post-opératoire.

Le médecin s'entretient avec le patient ou avec un membre responsable de sa famille dès que l'opération est décidée. Le médecin inscrit sur le dossier les renseignements qu'il donne au patient et à sa famille, puis il en informe le personnel d'infirmières. Les infirmières complètent les renseignements au patient. Si le patient ou la famille éprouvent de la difficulté à se décider à l'opération, le patient est référé au Service Social et des arrangements sont faits pour que la travailleuse sociale rencontre la famille durant les heures de visite.

L'infirmière discute avec le patient des aliments qui lui conviennent et qu'il peut tolérer; elle en prépare une liste qu'elle fait parvenir à la diététiste et l'informe de la journée de l'opération.

Phase II
Période post-opératoire quand le patient est au lit, et avant qu'il soit assez fort pour se rendre à la chambre de bain.

Aider le patient à accepter l'opération et les soins qu'elle requiert:

(a) Pansement, irrigation, soin de la peau.

Enseigner graduellement au patient comment se donner les soins énumérés plus haut.

(b) Diète: suivant la prescrip-

Le médecin prévient le personnel d'infirmières de la date probable du départ du patient, pour que le plan d'enseignement puisse être préparé. L'infirmière prépare un plan journalier et encourage le patient à participer aux soins en autant qu'il le peut; ce plan est écrit et conservé dans le dossier du patient. Une démonstration de la procédure des traitements est donnée au patient,

SOINS À DONNER AU PATIENT MANIÈRE D'ADMINISTRER LES SOINS

tion du médecin.

(c) Faire coïncider le plan des soins d'hôpital avec le genre de vie que le patient peut suivre chez lui.

S'informer quel sera le moment de la journée le mieux approprié pour les soins à donner.

Attitude de la famille concernant l'accueil du patient.

Possibilités à se procurer le nécessaire pour traitements, lorsque le patient sera chez lui.

Condition de travail et de récréation auxquelles le patient devra se réhabiliter.

Membre responsable de la famille qui pourra aider le patient pour les soins qu'il ne pourra se donner lui-même.

lequel retourne cette démonstration devant l'infirmière.

S'il est possible, l'infirmière organise une entrevue avec un patient rétabli qui a subi la même opération; si non, l'entrevue a lieu avec un patient du dispensaire.

L'infirmière donne les instructions concernant la liste de diète, prescrite par le médecin, qui est suivie à l'hôpital et qui devra l'être également quand le patient sera chez lui. S'il existe un problème à ce sujet, le patient est référé à la diététiste.

L'infirmière discute avec le patient, ou un membre responsable de sa famille, pour déterminer quels problèmes existent chez lui. Si plus d'informations sont nécessaires, le patient sera référé au service d'infirmières visiteuses sur une formule employée à cet effet. Les renseignements suivants seront indiqués: Investigation désirée — le diagnostic et pronostic du patient. Condition de l'opération permanente ou temporaire. Genre de traitements requis. Les renseignements qui ont été donnés au patient et à sa famille. Description de la réaction du patient et de sa famille concernant l'opération. Date probable du départ de l'hôpital. L'infirmière visiteuse aura une entrevue avec les infirmières du département de l'hôpital, et leur remettra un rapport écrit de sa visite à la demeure du patient, renseignant sur les conditions existantes.

L'infirmière fait coïncider le plan des soins d'hôpital avec les facilités existant à la demeure du patient.

Phase III

Période de convalescence quand le patient peut circuler et se rendre seul à la chambre de bain.

Aider le patient à devenir dépendant de lui-même, en autant que sa condition le permet; ceci en préparation pour son retour chez lui.

Soins variés que le patient devra se donner lui-même — pansement, irrigation, etc.

Se procurer de l'hôpital le nécessaire pour les soins de la première journée après son arrivée chez lui; l'aider à solutionner des problèmes qui pourront survenir concernant sa condition.

Retour au travail, aux distractions.

Au besoin, préparer un plan pour soins additionnels à son

L'infirmière se procure de l'extérieur (magasin ou pharmacie) le nécessaire pour traitements et enseigne au patient comment s'en servir; elle renseigne aussi le patient où il pourra s'en procurer à son retour chez lui.

Un feuillet contenant les instructions appropriées, est remis au patient, lui permettant d'y référer au besoin quand il sera chez lui.

L'infirmière lui aide à se servir de ces instructions durant qu'il est à l'hôpital. Si le patient est incapable de se donner tous les soins, l'infirmière fait venir à l'hôpital un membre responsable de la famille pour observer comment les soins sont donnés.

L'infirmière réfère le patient à un service

SOINS À DONNER AU PATIENT MANIÈRE D'ADMINISTRER LES SOINS

	retour chez lui. Heures de clinique.	d'infirmières visiteuses, si nécessaire; donne les explications concernant ce service ainsi que celui de la clinique.
<i>Phase IV</i> Soins à domicile.	Soins à domicile et retour au genre de vie habituel: Réhabilitation à l'entourage familial. Retour à un travail approprié et aux récréations. Solution de problèmes qui ont pu persister malgré les renseignements donnés. Surveillance de la condition générale du patient. Clinique. Visites de l'infirmière visiteuse, suivant le besoin.	Si le patient a été référé pour soins à domicile, l'infirmière visiteuse voit le patient le lendemain de son retour chez lui; pour l'aider à faire ses traitements et observe la condition familiale; et fait un plan pour d'autres visites si nécessaire.

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Cancer Treatment Facilities

There is a tendency at the present time on the part of well-meaning citizens of some of our smaller cities and towns to demand that all cancer treatment facilities be set up in their particular community. In the best interests of the cancer patient these demands can not be medically justified—nor can they be justified economically.

A population of 20,000 people does not produce a sufficient number of cases to allow for a large experience in the handling of cancer patients and does not produce a sufficient number of cases of all types to justify the setting up of the expensive radiotherapy equipment necessary for treatment of special cases, to say nothing of the trained personnel required to operate this equipment.

The following figures support such arguments. This same population of 20,000 will

have about 50 new cases of cancer per year. Certain types of cancer, such as of the skin will be more common than others. Nevertheless, it will take months or years to gain an experience with even as few as 10 cases of any given type of cancer. Ten cases of cancer of the skin might be expected to occur in 15 months, 10 of the breast in 16 months, 10 of the uterus in 2 years, of the bladder 5 years, the lung 7 years, the lip 8 years, the larynx 16 years, and 10 cases of brain tumor in 25 years.

Local pride in matters of medical care must give way to a reasonable understanding of the necessity for the concentration of all cancer treatment facilities only in those centres which draw from populations of large size.

—Canadian Cancer Society Newsletter

Weak eyesight may be the cause of a child's schoolwork suffering. By having the eyes of a school age child examined periodically more

serious conditions may be prevented from developing. At the same time the child's progress at school may be considerably helped.

Student Nurses

How People Live

THELMA CORMIER

Average reading time — 2 min. 24 sec.

HOW OFTEN, during the course of our training, do we stop to think or realize where our patients come from or where they go when they leave the hospital. Do we ask ourselves the very important question, "Will Mrs. Brown, who is paralyzed, have adequate care when she leaves the ward?" or "What will little Mary Smith do when she grows up?" A month with the Victorian Order of Nurses gives us some idea of how other people live.

The work of the V.O.N. consists in caring for medical, surgical, and chronic patients; instructing the expectant mother in the care of her health; assisting the doctor when the baby is born at home and giving nursing care and supervision to the mother and baby. The nurse is a health teacher in the home and shows by demonstration the nursing care which the family should give between her visits. She also conducts well-baby conferences, assists at immunization clinics, and does group teaching.

My first morning in the district was one of the most exciting experiences during my training. Everything was so new and different from my work on the wards in the hospital. Even the bag technique was interesting when I saw how much was packed compactly into such a small space.

My first two weeks were spent in the "Pier" district, which I enjoyed very much indeed. My work among the colored people in the part known as the "Coke Ovens" I liked espec-

ially. For a while I worked along with another nurse, but gradually I was allowed to go to some homes alone. Walking along the streets everyone spoke to me. They didn't know me but the fact that I was in a Victorian Order uniform, for a while at least, made them feel that they knew me. All the kiddies with their black shiny faces and broad grins would yell out: "Here comes the nurse—I must tell Mummy." Then they would crowd around me to the door.

Decrepit as many of the houses were on the outside, it was surprising how many of them were neat and tidy inside. A great many of them, to be sure, were little more than hovels or shacks. It is in places such as these that the nurse has to use her ingenuity to make things do. The cost of materials has to be considered in most cases, as illness always adds an extra burden on the pay cheque—if the husband or father is lucky enough to have such a thing.

I was quite surprised at how cooperative the patients were. The Victorian Order nurse is certainly a welcome figure to all. She is looked upon as a friend of the family who is able to share the burdens and sorrows of the individual. No one resents having the nurse tell them what to do, or how. Invariably they take her advice if at all possible.

When I returned to the hospital I found that I had a much better understanding of my patient after seeing him in his own home surroundings and as a member of the community. My affiliation also made me aware of the many social problems and of their effect upon health.

As a student nurse at City Hospital, Sydney, N.S., Miss Cormier enjoyed her affiliation experience.

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REPORT No. 3

UTILIZATION OF NUTRIENTS BY PREMATURE INFANTS

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This study is part of an extensive clinical research program now being conducted through grants-in-aid made by Swift's.

The Canadian Nurse

VOLUME 46

NUMBER 6

JUNE, 1950

NEW PRODUCTS.....	430
A SPRING OR A POND.....	437
VANCOUVER BY THE SEA.....	A. Wyness 439
HYPERTENSION.....	R. E. Beamish, M.D. and J. D. Adamson, M.D. 449
NURSING THE HYPERTENSIVE.....	M. Sigmundson and C. Einarson 455
PUBLIC HEALTH NURSE'S ROLE WITH THE HYPERTENSIVE.....	S. Petursson 458
WHO IS RESPONSIBLE?.....	A. J. Macleod 460
NURSING PROFILES.....	462
POST-ANESTHETIC RECOVERY ROOMS.....	E. Honey 465
PUBLIC HEALTH NURSING IN NEWFOUNDLAND.....	E. R. Summers 471
LE TRAVAIL MÉDICO-SOCIAL.....	J. Gagnon 474
LYLE CREELMAN WRITES.....	477
THE NURSE AND THE LAW.....	C. LeDoux 478
TRENDS IN NURSING.....	481
ORIENTATION ET TENDANCES EN NURSING.....	483
WORK CONFERENCES.....	485
NEWS NOTES.....	488
BOOK REVIEWS.....	498
OFFICIAL DIRECTORY.....	504

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checked my problem. ☐ ☐ ☐

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City.....Prov..... 177-6-50

**individually
designed SPENCER SUPPORTS**

Between Ourselves

This is it! The month toward which so many nurses have been looking forward—the month when we travel to Vancouver for the **25th convention of the Canadian Nurses' Association**.

The third largest city in Canada, Vancouver has long been a Mecca for travellers. There are so many interesting spots in the immediate environs of the city to visit, that those nurses who have never been there before will want to arrange to stay for an extra day or two so that they may do some sightseeing. **Alison Wyness** has sketched some fascinating word pictures to tempt you to linger longer.

* * *

Last July one of our very well-known Canadian nurses, **Lyle Creelman**, flew from Montreal to Geneva, via London, to become the consultant in Maternal and Child Hygiene in the World Health Organization. The personal letters she has written home have been so full of fascinating information that we have asked her to prepare a regular release for publication in *The Canadian Nurse* each month. The first appears in this issue, under the caption "**Lyle Creelman Writes.**" We know you will enjoy these glimpses of "faraway places with strange sounding names." Watch for them every month.

* * *

*While there are no figures available on the actual incidence of increased blood pressure, it is found very commonly. **Primary or essential hypertension** is a separate clinical entity. For some unknown reason vascular tone is increased. Hypertension develops without any determinable pathological changes in the beginning. With the persisting high*

blood pressure, eventually the clinical picture of damage to the blood vessels and other organs appears. Studies that have been made of essential hypertension seem to indicate that inheritance has some bearing on the problem.

Solving some of the problems of hypertension, while at the same time providing a place for treatment, is the role of the special clinic established at the Winnipeg General Hospital. **Dr. R. E. Beamish** and **Dr. J. D. Adamson** have prepared an excellent digest of the relevant facts for your information.

Supplementary nursing care information is contained in the article by **Margret Sigmondson** and **Clara Einarson**. One aspect of the community problem in hypertension is described by **Suzanne Petursson**.

* * *

*How can nurses assist with the **finding of clues** when victims of assault, etc., are brought into our hospitals? What should the nurse do with the clothes of an injured person? These and many other questions are answered in the interesting article by **Sub-Inspector Carl LeDoux** which begins in this issue. It is such a fascinating topic that even the stenographer in our office, who typed the copy to go to the printers, was loath to stop until she had finished. A long article, it will be spread over two or three issues.*

* * *

*The series of articles dealing with **evaluation and accreditation** is concluded with **Agnes J. Macleod's** challenge to the voting delegates at the forthcoming convention. The need for this type of service is clear. The expense involved would be more than justified in the years to come. Ponder the matter carefully before you vote.*

An interesting sidelight on the advancement of medical and pharmaceutical procedure is illustrated in an old pharmacy order, dated 1794, which was presented to Dean R. O. Hurst of the Ontario College of Pharmacy by Allen and Hanburys Ltd., London, Eng. Among a wide variety of medications and other drugs is a request for 24 lb. of opium.

The past 50 years have witnessed many great advances in medicine, but none more dramatic than the discovery that penicillin is truly a life-saver where cases of subacute bacterial endocarditis are concerned, it is stated by the Canadian Heart Association. Until 1944, it was rare for a person suffering from this heart ailment to recover—now, it is just about as rare for one to die.



Like an Angel of Mercy TO YOUR SKIN

**Dainty, Greaseless Skin Cream
Helps Hands, Complexions Look
Lovelier. Nurses find many other
uses for this Famous Beauty Aid**

● If you're ever troubled with annoying blemishes, dryness or roughness . . . if your hands are red and rough from having them in hot water or strong solutions too often—try Noxzema Skin Cream as a dainty, greaseless beauty aid.

Thousands of nurses use Noxzema every day as their all-purpose beauty cream—their regular powder base and night cream. You'll be delighted at the way this greaseless, medicated cream helps your skin look softer, smoother, lovelier.

And here are many other uses for Noxzema that nurses have discovered. After a tour of duty when your feet are burning and tired . . . smooth on cooling *medicated* Noxzema. See if you don't agree it's "like wading in a cool

stream." Or next time you shave your legs, apply this greaseless cream first . . . see if it doesn't take the drudgery out of shaving. And rub a little on your arms and elbows to help soften and smooth them.

There are many more beauty and comfort tips inside every package of this dainty cream. Try them. You'll be sharing the secret of smart women all over Canada who agree that dainty, greaseless Noxzema is truly "An Angel of Mercy" to their skin.

FOR YOUR PATIENTS' COMFORT

Try Noxzema Skin Cream to help heal the sore irritation of patients' sheet burns. They'll appreciate the delightful soothing relief they get from Noxzema's *medicated* formula. And here's a *new idea* in skin comfort they'll love! Use this dainty greaseless cream as a refreshing body massage. It's a wonderful skin tonic—will make them feel good *all over*! Noxzema is greaseless—so there's no worry about staining bed linen. Start using Noxzema *today*.

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

ALUDRINE HYDROCHLORIDE

Manufacturer—Eli Lilly and Company (Canada) Limited, Toronto.

Description—5 mg. and 10 mg. tablets of Aludrine (1-(3, 4-dihydroxyphenyl)-1-hydroxy-2-isopropyl-aminoethane) Hydrochloride; also called isopropylepinephrine.

Indications—Treatment of attacks of bronchial asthma and in control of status asthmaticus. Has shown results in cases which do not respond to epinephrine or theophylline.

Administration—Sublingually is often method of choice, usually in doses of 10 mg. for adults repeated as prescribed.

GRAMOLETS

Manufacturer—Schering Corporation Limited, Montreal

Description—Each troche contains 0.25 mg. Gramicidin (antibiotic) and 5 mg. Benzocaine in a palatable slowly-dissolving base.

Indications—For relief of throat irritations and infections due to gram-positive bacteria.

Administration—One every three hours or as prescribed, each sucked slowly until dissolved; not more than 8 should be taken during a 24-hour period.

GRAMINASIN

Manufacturer—Schering Corporation Limited, Montreal.

Description—An aqueous nasal solution containing 0.005% Gramicidin and 0.125% dl-desoxyephedrine hydrochloride.

Indications—For relief of nasal congestion and possible prevention of secondary invaders of the common cold.

Administration—2 or 3 drops into each nostril every 2 or 3 hours or as prescribed. Atomizer may be used. Not more than 6 daily applications of the dosage suggested should be used.

GRAMODERM

Manufacturer—Schering Corporation Limited, Montreal.

Description—Contains 0.25 mg. in each gm. of special ointment base (Procutan).

Indications—For prophylaxis and treatment of superficial skin infections due to gram-positive organisms, as in cuts, abrasions, infected eczematoid dermatitis, impetigo eczematodes, impetigo contagiosa, etc.

Administration—Topically, directly to affected part or on a dressing.

MACRON TABLETS

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each sugar-coated capsule-shaped, brown tablet represents:

Ferrous sulphate U.S.P.....	0.35 gm.	Pantothenic acid.....	2.0 mg.
Thiamine hydrochloride.....	2.0 mg.	Ascorbic acid.....	50.0 mg.
Riboflavin.....	2.0 mg.	Liver concentrate (boiling-	
Nicotinamide.....	10.0 mg.	water extract).....	0.5 gm.
Pyridoxine hydrochloride....	1.0 mg.		

Indications—For prophylaxis and treatment of secondary and nutritional anemias; not for pernicious anemia.

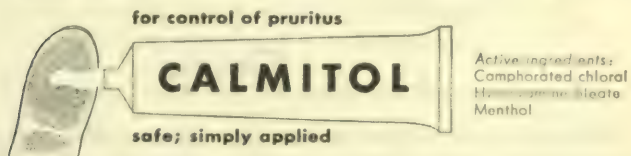
Administration—Prophylactically, as in pregnancy, one or two tablets daily. Therapeutically, usually three tablets daily.



massed attack

Poison ivy and many insects are notorious causes of severe pruritus. Prompt and safe control of the itching is a prime therapeutic need, for the patient's scratching or self-medication can lead to serious sequelae.

Calmitol Ointment gives relief directly upon application. It may be used liberally and repeatedly without the risk of exacerbation, for Calmitol Ointment is free from dangerous drugs such as phenol (as in calamine with phenol), cocaine and cocaine derivatives.



The Leeming Miles Co Ltd. 1 Notre Dame St., W., Montreal, Canada

P.A.S. TABLETS

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—Each tablet contains 0.5 gm. of paraaminosalicylic acid.

Indications—For adjunctive therapy in tuberculosis, particularly in toxic, febrile patients with acute exudative type.

Administration—Suggested dosage, 12 to 16 gm. daily in divided doses on a full stomach as far as possible. If digestive disturbances occur, the use of sodium bicarbonate or phenobarbitone and atropine will usually control symptoms. Acetylsalicylic acid is contraindicated in P. A. S. therapy.

TRONIC Compound

Manufacturer—Sharp & Dohme (Canada) Limited, Toronto.

Description—Each cc. contains:

Protein hydrolysate (45% amino acids).....	0.15 gm.	Calcium glycerophosphate...	2.80 mg.
Thiamine hydrochloride....	.088 mg.	Sodium glycerophosphate....	5.60 mg.
Riboflavin.....	.044 mg.	Manganese glycerophosphate	0.35 mg.
Pyridoxine hydrochloride....	.022 mg.	Potassium glycerophosphate.	0.53 mg.
Niacinamide.....	.660 mg.	Alcohol with flavoring agents	
		added.....	17%

Indications—As a dietary supplement in patients requiring Vitamin B-Compound therapy in conditions such as loss of appetite, various debilitated states, during pregnancy, and for growing children, and also in patients with febrile illness and after surgery in which there may be a delayed convalescence.

Administration—Recommended dosage for adults is one tablespoonful three times daily before or with meals. For children a proportional similar dosage is suggested. In the presence of frank deficiency the dosage may be increased at the discretion of the physician.

PROCAINE HYDROCHLORIDE 0.2%, intravenous

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Procaine Hydrochloride, U.S.P., 0.2% w/v, in Isotonic Sodium Chloride Solution for intravenous use. Each 500 cc. contains Procaine Hydrochloride, U.S.P., 1 gm., Sodium Chloride, U.S.P., 4.5 gm. in water for injection.

Indications—For intravenous infusion in painful conditions associated with extensive burns, arthritis, etc.

DERM CREAM

Manufacturer—Ingram & Bell Limited, Toronto.

Description—A soothing cream with water miscible base containing in each ounce:

Crude coal tar.....	2½%	Calamine B. C. P.....	2½%
Titanium dioxide.....	7½%	Cetyl trimethyl ammonium bromide	1%
Zinc oxide.....	7½%	Benzocaine.....	5%

Indications—For the treatment of atopic eczema and allied skin conditions. The use of a water miscible base permits easy removal and the incorporation of a local anesthetic gives prompt relief of irritation and alleviates the tendency to scratching.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Isabel Black*, B.S., has returned from Teachers College, Columbia University, to resume her work as regional supervisor with the Division of Public Health Nursing, Ontario Department of Health, with headquarters at North Bay; *Elizabeth Mac-*

pherson (Royal Infirmary, Scotland, and University of Edinburgh public health course) to Espanola; *Eleanor Reynolds* (Wellesley Hosp., Toronto, and University of Toronto general course) to Sault Ste. Marie Board of Education.

Resignation: *Edna Thomas* from Fort Frances to return to England.

BEREX—Succinate-Salicylate Therapy *in* ARTHRITIS RHEUMATISM

EXPERIENCE HAS PROVED that salicylates are the agent of choice in the treatment of Arthritic and Rheumatic disorders. But toxic and other unpleasant reactions often result when large and sustained dosage of salicylates is necessary in chronic and acute cases of Arthritic and Rheumatic disturbances.

This difficulty has been overcome. Clinically it has been demonstrated that the depressant effect of salicylate on blood prothrombin is averted when acetylsalicylic acid is administered in combination with calcium succinate as it is in BEREX.

BEREX combines these proven advantages:

- BEREX gives prompt relief of painful symptoms.
- BEREX obviates salicylate toxicity and may be prescribed without fear of untoward side-effects such as hypoprothrombinemia or hemorrhagic tendency and is, therefore, suitable for protracted therapy.
- BEREX is easily administered . . . reasonable in cost.

BEREX contains, per tablet: calcium-succinate 2.8 grams, acetylsalicylic acid, 3.7 grains.

BEREX may be obtained through your prescription pharmacy—in bottles of 100 tablets or in bottles of 500 tablets designed for dispensing and institutional use.

*Complete clinical information concerning BEREX in the treatment of
Arthritic and Rheumatic disorders will be sent on request to*

BEREX Pharmacal Co., 36-48 Caledonia Rd., Toronto, Canada

Patented 1919. Manufactured under License from the Proprietors.
BEREX is the trademark of this product.

a step forward

IN SIMPLE ANALGESIA

For 50 years acetylsalicylic acid in tablet form has proved of inestimable value to mankind. However these tablets are comparatively insoluble, and clinical investigation has demonstrated the irritant effect of the undissolved particles of acetylsalicylic acid on the gastric mucosa. For these reasons the calcium salt of acetylsalicylic acid — calcium acetylsalicylate — is to be preferred.

A step forward has been taken with 'DISPRIN', containing 5 grains acetylsalicylic acid and producing, in water, 6 grains of calcium acetylsalicylate. Thus, 'DISPRIN' offers all the well-known advantages of acetylsalicylic acid without its disadvantages.

'DISPRIN' is soluble and palatable. It can be administered with ease, especially to children. 'DISPRIN' is more speedily assimilated and less rapidly eliminated, thus accelerating the analgesic effect. 'DISPRIN' is substantially neutral and is less likely than ordinary acetylsalicylic acid to cause irritation of the gastric mucosa.

A trial supply and literature will be gladly sent on request.



SOLUBLE
NEUTRAL
PALATABLE
STABLE

RECKITT & COLMAN (CANADA) LIMITED
Pharmaceutical Division, Montreal

'DISPRIN' — by the makers of 'Dettol' Antiseptic

TAMPAX FACTS^{NO} 3

Properly used, they provide "complete absorption of the flow."⁴

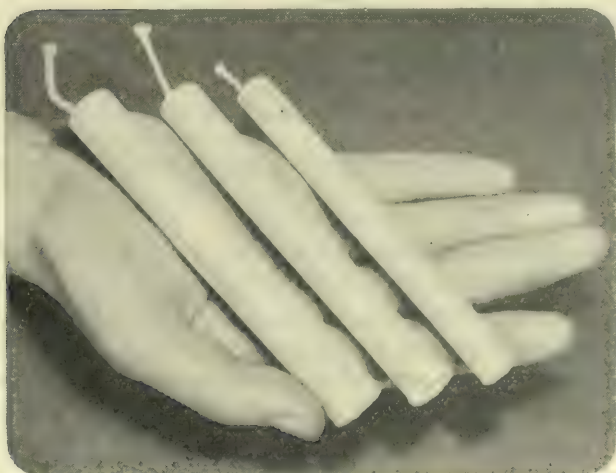
Correct tampon size in relation to vaginal length and caliber (with proper technique of insertion) are the only prerequisites of complete protection during the menstrual period.

Tests, under conditions of use with the expansion of the tampon restricted, indicate the average absorbency for Super TAMPAX as approximately 17 cc, for Regular TAMPAX approximately 12 cc and for Junior TAMPAX approximately 9 cc—whereas, actual clinical studies¹ of a representative group of women show the periodic flow to average only 50.55 cc. Thus, with correct usage and absorptive capacity of more than 170 cc, 120 cc and 90 cc in each package of ten Super—Regular—Junior TAMPAX tampons respectively, the margin of safety assures adequate protection for the entire period—simply by inserting the tampons at proper intervals.

Besides providing ample absorptive capacity, TAMPAX is safe,³ comfortable,⁴ and convenient.⁵

Its use has also been reported as psychologically beneficial.²

The fact that, during the last 14 years, over 2 billion TAMPAX have been purchased reflects the strong confidence that women place in their physicians' judgment.



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4. Med. Rec., 155:316, 1942.
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Available, at no cost, are professional samples of the three absorbencies of Tampax—Regular, Super and Junior. Just fill out and mail the coupon below.

TAMPAX

The Internal Menstrual Guard of Choice

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Brampton, Ontario.

Please send professional supply of TAMPAX in the three absorbencies and related literature.

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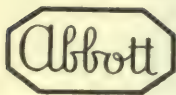
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THE VITAMIN HOUR

....can be like this!

When the Vi-Daylin bottle is opened, children come running. They smell this honey-like liquid, taste the lemon-candy flavor, and are quick to take the prescribed dose—no coaxing, no coyness here. One teaspoonful a day is the average dose for children up to twelve years old. Vi-Daylin is ideal for babies too, as it's easy to mix with formula, fruit juice or cereal. Contains practically no alcohol—less than 0.5%. For mothers there's an extra bonus—Vi-Daylin has no fishy odor, stays fresh without refrigeration. The formula shows its potency, the Abbott label assures you of its purity and stability. Vi-Daylin is obtainable in two convenient sizes: 90-cc. and 8-fluid-ounce. ABBOTT LABORATORIES, LIMITED, MONTREAL.

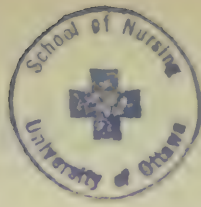


Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	5000 Int. units
Vitamin D	1000 Int. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Nicotinamide	10 mg.

SPECIFY *Vi-Daylin*
TRADE MARK

(HOMOGENIZED MIXTURE OF VITAMINS A,
D, B₁, B₂, C AND NICOTINAMIDE, ABBOTT)



The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION
VOLUME FORTY-SIX NUMBER SIX

MONTREAL, JUNE, 1950

A Spring or a Pond

Average reading time — 3 min. 12 sec.

ONE OF THE interesting and provocative parts of assembling each month's issue is the preparation of the material that comes under the caption, "In the Good Old Days." It calls for more than just a hurried scanning of this 40-year-old material. It provides a very valuable insight into the professional preoccupations of the nurse leaders of that day. Many of them have gone to their reward and remain only as names to most of us. The sprinkling who are still among us have long since ceased taking an active part in nursing affairs though, interestingly enough, many of them are still subscribers to the *Journal* and follow the present-day developments in nursing education and nursing service with unquenchable enthusiasm.

One of the most interesting monthly issues so far reviewed was the July, 1910, number. The entire issue was devoted to the papers given and a verbatim report of the discussion that took place at the fourth annual meeting of the Canadian Society of Superintendents of Training Schools for Nurses. It is altogether probable that no one else has read this particular

issue through with care for at least 39 years. A few brief excerpts from it will be published next month. If space would permit, it might prove very stimulating to reproduce several of the papers for so many of their points are still plaguing us professionally. The most hopeful sign is that nowadays, instead of these matters being mulled over by a small handful of superintendents of nurses, they are being tackled by hundreds of interested nurses all over Canada. Many of the related topics will be discussed during the forthcoming convention in Vancouver.

What are some of these problems that perplexed the nurses of 40 years ago? In her paper on "What the Nurse Owes the Hospital—the Profession—the Registry," Miss Barwick deplored the attitude of young graduates "who seem to think it is their privilege to begin where their older sisters are leaving off." These young upstarts of 40 years ago coolly decided for themselves what types of cases they would and would not nurse! They scorned night duty—there was no such thing as a 3-11 shift in that day or they would doubtless have

been recorded as spurning it too. We still hear the same note of criticism. Nurses have not changed much in 40 years.

Another source of worry was reflected in the paper by Miss Mary Ard MacKenzie, superintendent of the Victorian Order of Nurses, when she said:

Every graduate nurse should have impressed on her, before graduation, the meaning and importance of an engagement, an agreement or a contract, so that none of them will, as so many do now, regard a contract as something that may be set aside when anything more tempting offers itself.

That still has a familiar ring, hasn't it?

A third speaker was very much concerned over the lack of interest taken by nurses in their own professional associations. Another startled the assembly of superintendents by suggesting the forerunner of our present student nurse recruitment campaigns—that every training school should send a representative to talk to girls in high schools and colleges regarding nursing.

Thus we see that so many of the problems that concern us today are not new. They are still awaiting solution. Are we any closer to finding

answers or will our colleagues in another 40 years look back to the reports and discussions of this year's convention and say, "They did not travel very far in solving the problems of nursing."

Several momentous decisions await the voting delegates who will attend this 25th convention of the Canadian Nurses' Association. Through the medium of the *Journal*, these matters have been placed before thousands upon thousands of our members. Our greater strength to meet and solve our problems lies in the multitude of small, local nursing organizations that can, if they will, help to provide the answers.

Perhaps our greatest need today is that each of us should resemble a spring, not a pond. Flowing from the depths, a spring is clear, sparkling, life-giving. A pond is stagnant, dull, and lifeless. A spring gushes out to spread over a wide area. A pond lies inert, a home for croaking frogs. If, like a spring, ideas flow from the depths of our thinking at this year's convention, the vitalizing effect will be felt in nursing all over Canada. If the participants are as indifferent as a pond, progress will be curbed. Are you a spring or a pond?

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

Appointments—Calgary: *Lois Maxwell* (Edmonton Gen. Hosp.). Halifax: *Joan Townsend* (Victoria Gen. Hosp., Halifax). Kingston: *Joyce Brightwell* (St. Mary's Hosp., Timmins). Saint John, N.B.: *Charlotte Myles* (Royal Victoria Hosp., Montreal). Toronto: *Elizabeth LePan* (Toronto Gen. Hosp.). Vancouver: *Grace Lackey* (Royal Victoria Hosp., Montreal). York Township, Ont.: *Vera Jolley* (Royal Infirmary, Sheffield, Eng.).

Re-appointment—Moose Jaw: *Catherine Ross* as nurse in charge.

Transfer—*Elizabeth Ferguson* from Arnprior, Ont., as nurse in charge to Kirkland Lake, Ont., as nurse in charge.

Resignations—Calgary: *Eileen Williams*. Chatham, Ont.: *Elsie Jackson*. Kirkland Lake: *Marguerite McNamara* as nurse in charge. Toronto: *Lois Gorman*, *Barbara Hincks*, *Margaret Kerr*. Truro, N.S.: *Mona Roberts* as nurse in charge. Welland, Ont.: *Olive Orton*. York Township: *Marion Fricke*, *Alice Veenis*.

Many people whose younger years were busy, happy and productive feel lost, unhappy and unwanted in their declining years. Guard against this feeling of frustration by

preparing yourself for the twilight years. At least ten years before you think of retiring start planning your hobbies for your leisure days.

Vancouver by the Sea

ALISON WYNESS, B.A.Sc.

Average reading time — 24 min. 6 sec.

Land of today and tomorrow—fresh as the morning dew.₁

KLA — HOW — YAH TILlicum!₅

VANCOUVER is a city of promise, of opportunity, and of truly great challenge! Largely due to her unique geographical heritage, she not only has rare beauty herself but can also open many doors for you. These will lead you into lands of great splendor and unparalleled loveliness. Some of these trips are near—others, as far distant as the blue Pacific itself. When you are here you cannot help but catch something of the newness of it all—the ruggedness and the space that surrounds Vancouver.

When you pass in and out of her harbor, you will follow the same route as that once navigated by Captain Vancouver in June, 1792. He and his companions were the first white men to enter the inner harbor of the city that bears his name. The previous year, Spaniards had sailed into the outer harbor. Today, the shore-line, where the historic meeting took place between Captain Vancouver and the Spaniards, is known as "Spanish Banks." The historic occasion is recorded on a landmark located on Marine Drive near the University.

You have heard of Stanley Park. Even though it is situated very close to the business centre of town—Paradise could hardly be more beautiful or more varied in appeal. There is something there for everyone. Untamed woods, beautiful man-made rose gardens, recreation of many types—boating, swimming, tennis, golf, riding, cricket, and the ageless joy of hiking through woodland trails that cut deep into forests centuries old. It is surrounded by the sparkling waters of English Bay and Burrard Inlet. On these waters the ships pass—perhaps a great liner from the Orient or just a little pleasure boat

or maybe a fishing-smack laden with its morning catch.

Often, you can see little children at play on the sands of the famous beaches or old folk enjoying the companionship of a cosy chat by the sea. You will want to spend some time listening to the birds and other wild life that abounds in the more secluded areas of this 1,000-acre park. A spot you might choose would be along the trail that leads to the "Seven Sisters." Historically, these stalwart Douglas firs were named for seven little girls who lived in Vancouver when it was very, very young. However, the Indians have a unique legend which partly explains why the trees never fail to give a sense of peace and security. This legend, retold by Pauline Johnson, one of Canada's outstanding poets and writers, is called "The Lure in Stanley Park."

The lure originally was an evil soul. The Indians dreaded this witch-like character more than anything else. The great God of the Indians, known as the Sagalie Tyee, was filled with sorrow that



City Archives, Vancouver

The Seven Sisters in the background.

his children should be so afflicted by this evil spirit. As a result, he commanded "His Four Men" (always representing the Deity) that they should turn this evil spirit into stone, so that the curse might be lifted. This the four men did. However, fearing that the evil spirit might still try to work destruction, they decided that at the end of the trail they must place something so good and great that it would be stronger and more powerful than this evil. Only in this way could it truly be overcome. "So they chose from their nation, seven of the kindest men—men whose hearts were filled with love of their fellow-man—and transformed these merciful souls into the stately group of "Cathedral Trees."⁴

Vancouver coast Indians will tell you that this legend reveals their love for kindness and their hatred of cruelty. It also reveals their great love of trees.

Their saps and gums, their fibres, their leaves, their blossoms enrich, nourish, and sustain the human form; no evil is produced by trees—all, all is goodness, is hearty, is helpfulness and growth. This service to mankind is priceless.⁴

Perhaps you, too, will catch this atmosphere of holiness when you take the trail leading to the "Seven Sisters"!

One of the most interesting features of the Park from the white man's point of view is the "9 o'clock gun." This is an old muzzle-loader made in 1816 in the reign of George III. It bears the coronet and initial "M" of the Earl of Musgrave, Master General of Ordnance at that time. The gun was brought to Vancouver about 1894 and was originally fired only at nine p.m. on Saturdays and Sundays to warn fishermen of the Sunday closing during the fishing season. As the fishermen began to go further afield, the gun lost its effectiveness. This custom was a great convenience for the early settlers as it gave them the correct time each evening. Even though the years have given us the telephone and radio to check our clocks by, the gun still is fired at nine o'clock each evening. The only

exception occurred during the war, when it was thought that the flash of the explosion might give information to the enemy. Happily, that period has passed and the people of Vancouver—at home, in church, or wherever they may be—automatically check their watches at 9:00 p.m.

This gun is located at Brockton Point, on the main Park Driveway which follows the sea. A little further on, you will notice the Totem Pole village on a hill above the pool for children's swimming classes. Still further on is Prospect Point and below it is "Siwash Rock," a real landmark with a fascinating Indian Legend. Originally this landmark was known as "Nine Pin Rock."

From both Brockton and Prospect Point the traveller gains a wonderful impression of the mountains of the coast range that guard Vancouver. Unless shrouded in rain and mist, they are a truly majestic sight to behold. Most of their peaks are snow-capped throughout the seasons and at sunset are specially magnificent—so mystic—so immovable and strangely beautiful.

The most famous peaks are "The Lions." They are commonly known by their British name, being called after the Landseer Lions in Trafalgar Square. However, those of you who love legend and Indian lore be sure to read their story by Pauline Johnson and find out why the Indians call them "Chee-Chee-Yoh-ee," meaning Twins or the two sisters, Peace and Brotherhood.

At the feet of these mountains are found the residential areas of North and West Vancouver. At night their many lights twinkle like candles on the dark hillside. The newest and shortest approach to West Vancouver is over the Lion's Gate Bridge. The construction of this particular bridge is well worth consideration. The more you study it, the more impressed you will be with the engineering skills involved. It was officially opened in November, 1938. The King and Queen drove over it the following year.

When you leave the Lion's Gate Bridge you reach the Capilano River.

Its course, the dividing line between North and West Vancouver, is one of beauty and grandeur. The river forms a series of canyons over which transportation has been provided for foot travel by means of suspension bridge and cable. There is an attractive tea-room with picnic gardens at the first canyon. In its small entrance park some Indian Totem poles have been collected and add to the picturesqueness of the scene.

The bridge at this particular spot is 450 feet high! It does seem to sway on its steel cables, as you make your way to the opposite bank of the river. Your efforts will be well rewarded for, at the end of the bridge, by the river below, you can find many delightful woodland spots—suitable for a noon-day picnic or evening supper. The further you journey up the Canyon, the wilder becomes the river with the scenery more and more rugged. Here you will find an example of the untamed virility of British Columbia!

If you would like an excellent panoramic view of Vancouver itself, there are two vantage points—one in West Vancouver, the other in North Vancouver. Both are easily reached by motor car. The former is found at the "Lookout" on the British Pacific Properties. This is a new and very special residential area located 1,500 feet above sea level. Her Majesty the Queen, on visiting this spot in May, 1939, is said to have remarked, "I think this is the place to live!" The other vantage point is to be found 3,800 feet above sea-level at the Chalet atop Grouse Mountain. Here you can dine and dance, watching the lights of Vancouver come on, each shedding its own glitter across the inlet waters below.

Nearby are Lynn and Seymour Canyons, each carved by their respective rivers. They are delightful to explore and to picnic. Each has rugged charm, rushing waters. Each has its own possession of pebbles, gleaming white and silver—sometimes wet with rain, often bathed in sunshine.

In the realms of commerce and industry, Vancouver's progress has



been extraordinary, especially in the past decade. In 1870, following the building of the two sawmills, Hastings and Moodyville, a small clearing was made in the forest on the shores of Burrard Inlet. This clearing was called Granville. (Today the main business thoroughfare has retained the name.) This small settlement boasted a two-cell jail, a "customs house," a saloon whose popular proprietor was a very colorful gentleman. His racy tales and stories earned for him the title "Gassy Jack." As a result the clearing was later known as "Gastown." You will find this early name recorded on the admiralty charts and other documents of that day. However, in 1884, Van Horne, of the Canadian Pacific Railway, felt a name should be chosen that was worthy of its possible destiny. He, in turn, is supposed to have mentioned to young Hamilton (the surveyor who laid out what is now Hastings St.), "Hamilton, this is destined to be a great city, perhaps the greatest in Canada, and we must see that it has a name commensurate with its dignity and importance, and Vancouver it shall be if I have my way."⁶

On April 6, 1886, Vancouver was incorporated as a city. Unfortunately, fire completely wiped it out in June of the same year, the population at

this time being about 2,000. This is a startling contrast to the present metropolitan population of 505,000. However, it did not take those courageous pioneers long to reestablish themselves. Rebuilding was begun immediately and on September 1, 1886, the first bank, known as the Bank of British Columbia, was opened. Although the first school with its 11 pupils was opened in 1873, it was replaced by a larger unit after the fire, for by that time it had grown to care for 90 pupils. Commercial use of the harbor was made during this year. It may be of interest to note that Vancouver Harbor has 98.2 miles of water frontage, with 48.78 square miles of deep-sea anchorage.

Industrially, Vancouver is still expanding: lumber manufacturing, fish processing, and deep-sea shipping being its prime industries. As the population increases one can expect further development in the field of manufacture.

If you travel to Vancouver by railway this summer, remember that it is just 63 years ago since the first trans-continental train reached our city. That was a great day in the history of the Canadian Pacific Railway, of Canada, and of Vancouver. By the vision of great souls and engineering skill, the isolation of the early pioneers was overcome. Coast to coast was now linked by bands of steel. Thus, a truly great contribution had been made to the cause of Canadian unity and progress.

Since those years, much has been accomplished to further our communication with the rest of Canada. Although the Rocky Mountains form a definite natural barrier, they are now traversed by air as well as train. The city's international airport has the record of being the safest on the North American continent. It is located near the mouth of the Fraser River, eight miles from the centre of the city.

As a city develops and grows older, many fine buildings are gradually erected. Among the more recent is the City Hall built at a cost of one million dollars. It was financed by "baby



Top of the City Hall



You sail from here going to Victoria.

bonds" and is now completely paid for. Then there is the new Hotel Vancouver. It is jointly owned by the two trans-Canada railway companies. Those experienced to judge have said it is one of the Dominion's best. Finally, you will notice the Marine Building. It is the tallest commercial building and has a green copper roof with penthouse. From the sea, coming into the harbor, it is an outstanding landmark and adds greatly to the character of the city's skyline. It is also the centre of business activity and home of the Vancouver Board of Trade.

There are churches of every creed and denomination. Among them are the Jewish Synagogue, the Catholic Cathedral, the Sikh Temple, the Greek Orthodox Church, and the Citadel of the Salvation Army. Some are of exceptional beauty and fine architecture. One of these, a United Church, is Canadian Memorial, built in memory of Canada's valiant dead who made the supreme sacrifice in World War I. Perhaps the most picturesque is the small Anglican Church of "St. Francis in the Woods"

at Caulfeild in West Vancouver. Each is making a worthwhile contribution to the spiritual life of this cosmopolitan seaport town where individual souls are still considered of priceless worth, and the family, the basic unit, in our endeavor to develop good citizens.

As Vancouver is a seaport, one can expect much activity about her harbor. At any time of the day or night, there is life and color on her extensive waterfront. This is largely due to the fact that 50 deep-sea steamship lines make her a regular port of call. Imports from 35 countries and exports to 52 countries are part of her busy life. The cosmopolitan atmosphere which results can be seen in different ways. Perhaps of special interest to the traveller are the many fascinating stores and restaurants that can be found in the Chinese section. The Italian quarter is developing rapidly and is interested in catering to restaurant trade, serving special dishes reminiscent of Sunny Italy.

There is much material in Vancouver that can be used to develop an appreciation of the different cul-



Aerial view of University of British Columbia with Howe Sound in background.

tures. One concrete example of this is the excellent Folk Festival that is usually an annual event. Each different national group is assisting to build a cultural awareness in the fine art of living. As a result both the Art Gallery and symphony society are gaining much needed public support and talent. Nurses seem to spend much of their leisure time enjoying the cultural assets of this still comparatively young city. Naturally, transportation costs limit the number and variety of outside attractions that we can offer. Perhaps the summer concerts given in the Park are the most unique. There, under the stars on summer evenings, many light operas and similar musical shows are enjoyed by large, enthusiastic audiences.

The University of British Columbia, one of the finest of such institutions in Canada, is situated in Vancouver. As one studies the story of its early beginnings and realizes the many hardships that had to be overcome, one is impressed with the present development. This achievement has been made possible by the active concern of each successive student body in the present and future welfare of their Alma Mater. In fact,

it is the very fibre of the University's progress. Their motto *Tuum Est* generally translated to mean, "It is up to you!", has been carried out faithfully by each new group of students so that today it is established as a tradition. Dr. MacKenzie, the present president, told a large group of high school students recently that the University of British Columbia is fast becoming one of the world's great universities.

Let us review some of its stimulating past. In 1877, John Jessop, provincial superintendent of education, first suggested a university for British Columbia. Not until 1890 was Dr. I. W. Powell of Victoria appointed chancellor and a senate elected. The next step, eight years later, was the establishment of Vancouver College. This was affiliated with McGill University, to offer the first year in arts. In 1906, McGill University College of British Columbia was established. The following year, an act was passed endowing the university with 2,000,000 acres of Crown Lands and in 1908 the old Act of 1890 was repealed. The New Act with amendments determines the present constitution of the university.

The committee chose Point Grey as the best location. This site was granted in 1911. This grant was later increased to 548 acres. In 1912 the tenders for four buildings were called. Construction was begun early in 1914. Then came World War I and all further development stopped. The bare girders were the bitter symbol of disappointment. True to the tradition of the west, in spite of these facts, the University of British Columbia opened its doors in 1915. Location was then in buildings of the Vancouver General Hospital, some wooden buildings being known as the "Fairview Shacks." The first enrolment was 379 students; today it is about 8,000. With the gradual levelling off of veteran students, an average enrolment of 4,500 is expected.

By 1919, these quarters were most inadequate and truly overcrowded. Early in 1922, students began agitating for action in building the university on the Point Grey site. They formed a most productive Publicity Campaign Committee.

This group did a magnificent job of organization and succeeded in convincing the provincial legislature of the need to continue the building of the University of British Columbia in Point Grey. One example of their untiring zeal is this fact: When the signatures on their petition were counted, there were found to be over 56,000. It is said that it required six page boys to present the rolls to the House! The petition now rests in our Provincial Archives.

Today, 28 years later, their efforts are not only gratefully remembered by the university, but also serve as a challenge to each succeeding group of students to carry on in developing this the second largest Canadian university.

The publicity campaign also included a trek, or parade to the Point Grey site. In protest against government inertia, each student, when he arrived at the new site, picked up a stone and hurled it into a spot near the uncompleted science building. Later, on this site, the stones were made into a Cairn. It is of interest to



UBC Science Building

note that the names of over 1,000 students, who took part in the parade, are inscribed on a paper preserved within the Cairn.

It was not until the fall of 1925 that the buildings were ready for occupancy. From this time the history of the university has moved very rapidly indeed. Even during the depression of the thirties several buildings were added. Student endeavor was largely responsible for these important additions. Among these were the student union building, "Brock Hall," in memory of the late Dean and Mrs. Brock; the old gymnasium, the playing fields and stadium. A rough stone monument, itself dating back to the glacial age, has



The Cairn

been erected by the university to commemorate the generous actions of the student bodies in providing their Alma Mater with these buildings.

Several buildings are under construction at the present time. These include the new War Memorial Gymnasium—a student and alumni project. The biological sciences and the women's residences are expected to be opened this fall. The preventive medicine building, which will include the Department of Nursing, should be started shortly.

Many good examples of Indian art are located at various sites on the campus. The most recent is that carved by Ellen and Edward Neel and donated by them to the university in

October, 1948. It is known as "The Thunderbird Totem" and was presented to the Alma Mater Society by Chief William Scow. You will find it just outside Brock Hall.

The University Library is well worth a visit, with its historical scenes of B.C. executed by John Innes. Its museum and art gallery are other points of interest you should not miss. You may be interested to know that this is Canada's only university library building west of Ontario. You pause in your observation to ponder. Vancouver may be irresistible, her beauty impressive, for a city so new she does aspire to much in the realms of culture. However, her poets and artists are still too few. Therefore,



Courtesy of Vancouver Tourist Bureau

The Parliament Buildings at Victoria

we can, perhaps, think of the universality as a symbol of the values which her poets and painters of the future will express to us in their own inimitable way.

To believe that there is something really great and excellent in the world, surviving all the shocks of accident and fluctuations of opinion . . . which gives immortality to human thoughts and actions, and catches the flame of enthusiasm from all nations and ages.⁶

Lovely and varied as are the attractions of Vancouver, the surrounding towns and resorts you can reach from her door-step are many. One of the finest of these is Harrison Hot Springs, reached by car or bus, a distance of about 90 miles up the Fraser. The spa itself is situated on the shores of a large lake, surrounded by mountains. A most inviting woodland path takes you in ten minutes to the natural springs of potash and sulphur. They are used for medicinal purposes by many seeking better health and freedom from various types of rheumatic conditions.

You can return by way of Chilliwack with its rich, fertile farm lands, coming eventually to New Westminster, a thriving, quaint town situated high above the Fraser. A magnificent view of mountains and river can be obtained from the Patullo Bridge, which spans the river at this point and leads to the United States border.

From Vancouver's harbor, pleasure boats go to many attractive spots located on the various bays and inlets. Bowen Island, in beautiful Howe Sound, is one of these, while Wigwam Inn at Indian River on the North Arm of Burrard Inlet is another.

Both these trips can be easily taken in a day or even an afternoon. For those wishing to go further afield and enjoy the relaxation of a lengthier sea voyage, Alaska is one of the great summer attractions. One should allow about two weeks for this very scenic and restful journey.

For a delightful week-end jaunt, the boat trips to Vancouver Island are a joy. You can go either by Nanaimo

or Victoria. Many plan to make the triangle trip — take the boat to Nanaimo, motor down the Island Highway to Victoria, and return to Vancouver by boat from this demure and charming city, the capital of British Columbia. It has a leisure and beauty all its own. The pace of life is slower, and everywhere, the quiet peace and serenity of the sea.

Vancouver awaits the nurses of Canada and extends to them a most cordial invitation to enjoy all she can offer. There is a special place in her heart, not only for the newcomer, but also for those who are her own—those who return at this time to share once more the fellowship of her people and the inspiration of Nature's beauty within her gates.

Then, with your memorable visit over, you will recall—

*Sounds of the seas grow fainter,
Sounds of the sands have sped.
The sweep of the gales,
The far white sails,
Are silent, spent and dead.*

*Sounds of the days of summer
Murmur and die away,
And distance hides
The long, low tides,
As night shuts out the day.³*

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Note: Information on "9 o'clock gun" taken from article on Vancouver written by Miss Francis of Vancouver Tourist Bureau. 1950.

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Oil of Wintergreen is Dangerous

IRENE P. THEAKSTON

About 8:00 a.m., one day last December, our two-year-old son, George, got hold of a bottle of synthetic oil of wintergreen. From the appearance of the bottle he swallowed about a half teaspoonful at the very most. I immediately gave him milk, followed by an emetic of mustard and water. After he had vomited there seemed to be no ill effects and he played about as usual. Shortly after 11:00 a.m. Georgie suddenly became cyanosed and his respirations were labored. Within 15 minutes I had him at the Children's Hospital and they immediately did a gastric lavage. Our family pediatrician said the return from the lavage was clean and did not have even a "stomachy" odor.

Georgie was then given a continuous intravenous of 5% glucose in water for 24 hours, $\frac{1}{2}$ cc. caffeine sodium benzoate, q. 4 h. for 3 doses, and $\frac{1}{4}$ cc. for 2 doses as a respiratory stimulant. It was not until midnight that the doctor said he was out of danger. Urinalysis the next day showed albumin plus 4 and the blood chemistry showed the N.P.N. elevated. Three days later the urinalysis showed albumin plus 2 with the N.P.N. normal. We were able to bring our son home. He was put on a low protein diet. He should

have been kept in bed two or three days but, due to his usual hyperactivity, that was hard.

Apparently many people are ignorant of the danger of oil of wintergreen when taken internally. I may have a poor memory but I do not recall being taught how dangerous this medication is (although I knew it was not good for a child to drink!) and cannot recall seeing it mentioned in first aid books along with other poisons. Other nurses whom I have asked tell the same story. Even our neighborhood druggist was unaware of its dangers.

Our pediatrician explained the "delayed action." Sometimes the reaction does not occur for 6-8 hours after the wintergreen has been taken. He said there have been some very tragic results from an overdose. Although its poisonous effect is not as rapid as that of some other poisons, the general public, and especially nurses, should be taught more about the drug—its dangers, symptoms of overdose, etc.

On the bottle's label are these words: "Poison—so labelled to comply with the law, but dosage given is perfectly safe." "Dose—10 gtt. on sugar q. 4 h." There is no skull and crossbones, nor is there any antidote printed on the label.

It only takes *one* act of carelessness to cause illness and perhaps death. We will forever thank God for sparing our little boy.

Mrs. Theakston is a 1938 graduate of the Calgary General Hospital and resides now in Halifax.

Your heart is smaller than your fist, yet it pumps enough to fill a railroad tank car every two days.

Hypertension

R. E. BEAMISH, M.D. and J. D. ADAMSON, M.D.

with assistance of DOROTHY LOW GRIFFIN, A.R.R.C.

Average reading time — 19 min. 12 sec.

SINCE cardiovascular diseases are by far the commonest cause of death, and since hypertension is the commonest vascular disorder, it follows that hypertension is one of the commonest diseases encountered by the nurse both at the hospital bedside and in the home. There is probably no disease in which an optimistic, well-informed attitude on the part of the nurse is so essential to the welfare of the patient. This is because the disease is usually chronic, its victims much benefitted by reassurance, and because simple hygienic measures are most helpful in its management.

DEFINITIONS

The word "hypertension" is by common usage synonymous with "high blood pressure" and denotes increased intra-arterial pressure. The pressure during ventricular contraction is known as the systolic pressure while that during ventricular relaxation is called diastolic pressure. The abnormal elevation may affect only the systolic level but most commonly affects both systolic and diastolic readings. Systolic hypertension occurs in aortic incompetence, hyperthyroidism, heart block, polycythemia, and arteriosclerosis, and its significance and treatment is only that of the associated condition. Diastolic hypertension, however, since it greatly increases the work of the heart, is of much greater importance. It is the variety found in acute and chronic renal disease and, most important of all, in that kind of hypertension of unknown etiology called "essential hypertension."

It is important to remember that "hypertension" is only a sign, not a disease. When an elevated reading is

encountered, one must carefully consider, firstly, whether or not the finding is significant and, secondly, if it is, how it may affect health and life expectancy.

HISTORY

The association of cardiac enlargement with renal disease was noted a century ago by Bright but, of course, the mechanism of such association was unknown. With the development of the sphygmomanometer in the 1880's, the widespread occurrence of high blood pressure (with cardiac enlargement and renal damage) was realized. It was natural that clinicians of that time should attribute hypertension to a renal cause. However, as knowledge of blood pressure increased, it was noted that many hypertensives had apparently normal renal function. Accordingly, in the early years of this century, a large group of patients was separated from the chronic nephritics and a new entity, "hyperpiesia" or essential hypertension, was born. This was largely a result of the work of Sir Clifford Allbutt in England.

The cause of this condition was considered obscure until in 1934 Goldblatt again directed attention towards the kidneys. He showed that in animals a lasting hypertension occurs after partial compression of one or both main renal arteries by a metal clamp. It was thus apparent that renal ischemia could produce experimental hypertension. This started a controversy which is still going on as to whether or not hypertension in humans is of renal origin. Although prodigious efforts have been made to settle the point, and much knowledge of experimental hypertension gained, it is generally considered that experimental and essential hypertension are different and that the etiology of essential hypertension still remains completely unknown.

Dr. Beamish and Dr. Adamson are associated with the Hypertension Clinic, Winnipeg General Hospital.

FACTORS CONTROLLING BLOOD PRESSURE

In the normal person there are several factors which combine to maintain normal blood pressure: (1) the cardiac output; (2) the peripheral resistance; (3) the total blood volume; (4) the viscosity of the blood; (5) the elasticity of the arterial walls. In essential hypertension all of these factors are normal except the second; it is increased peripheral resistance due to arteriolar vasoconstriction which is the fundamental hemodynamic alteration in the disease. The cause or causes of this increased peripheral resistance constitutes the riddle of essential hypertension.

Wide variations in blood pressure take place in normal people during their usual activities. This is illustrated in *Fig. 1* which shows the fluctuations found in a normal youth during a quiet day at home. No physical or emotional strain occurred during the day, but still the systolic pressure varied from 105 to 135 and the diastolic from 65 to 90 in response to changes of posture, digestion, and sedentary work. If much activity, mental or physical, had been indulged in, the swing might have been much wider in range. This is a completely normal record and represents what occurs in most people.

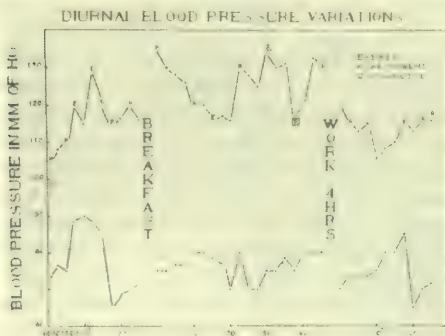


Fig. 1. Variation in blood pressure in a normal youth.

Because of these wide variations in normal persons due to emotional states, posture, exertion, digestion, etc., it has been difficult to establish the level above which a patient should be considered hypertensive.

It is at once apparent that the above variations can be controlled by taking the blood pressure readings in a uniform way under basal conditions comparable to those used when the basal metabolic rate is being measured. Readings obtained under these conditions constitute the "basal blood pressure." It is generally agreed that levels exceeding 140/90 repeatedly obtained under these circumstances are abnormal and denote hypertension.

In the hypertension clinic outpatients are allowed to have breakfast prior to coming to the hospital but otherwise are handled in such a way as to obtain basal readings. Each patient is admitted to a quiet room, lies on an examining table, whereupon readings are taken over a 45-minute period. Determinations done in the same way by the same observer month after month make for better relaxation. It is not uncommon for the systolic pressure to fall 20 to 40 mm. and the diastolic to fall 10 to 20 mm. during a single visit. This emphasizes the absurdity of patients and physicians alike paying any attention to rises or falls in pressure when single "snapshot" readings are taken, either in the physician's office or in hospital clinic. Yet one commonly sees patients whose hopes rise and fall with the manometric reading—and physicians who attribute success or failure to various treatments on the same unreliable evidence.

ESSENTIAL HYPERTENSION

In the early stages essential hypertension is merely a state of accentuation of the physiological variations noted above. For some unknown reason the psychosomatic mechanism which governs blood pressure becomes more sensitive so that stimuli produce responses that are abnormally great and unduly prolonged. A condition of paroxysmal hypertension is thus produced and may last for many years. As time goes on the rises tend to be higher and the falls less until eventually there is a sustained elevation. The steady rise of systolic and diastolic pressure, with an overlay of fluctuations in a case of benign hyper-

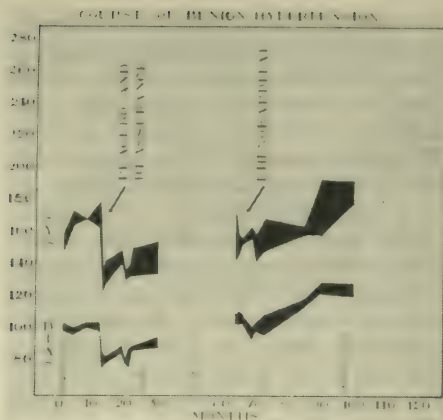


Fig. 2.

tension observed over a period of nine years, is shown in Fig. 2.

Sometimes the tempo of hypertensive disease is unaccountably speeded up. Such cases, characterized by very high diastolic pressure, papilledema of the optic discs, and a rapid downhill course, are termed "malignant." In some instances, usually young adults, the disease may begin this way; in other cases the malignant phase interrupts the course of ordinary benign hypertension and brings it to a rapid close. Such an event is illustrated in Fig. 3.

SYMPTOMS

There are no symptoms in hypertension due to the disease itself until the later stages. However, there are commonly three groups of symptoms in hypertensive patients:

1. *Psychoneurotic symptoms:* Many hypertensive patients are "highstrung," over-active people who suffer from a psychoneurosis as well as hypertension. As a result of emotional problems and various maladjustments to their environment they complain of symptoms referable to any or all parts of the body: headaches, dizziness, inability to relax, palpitation, pain in the left chest, etc. These symptoms are invariably due to the psychoneurosis and not to the accompanying hypertension. This can be proven by treating such patients with a placebo (e.g., colored water) and noting dramatic relief of symptoms. Unfortunately, many psychoneurotics are made much worse by being told that their blood

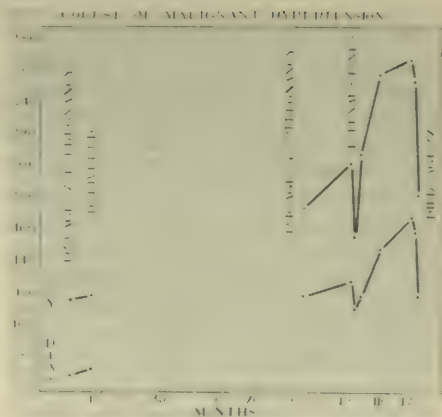


Fig. 3. Patient seen at age 27 with normal blood pressure. Again seen at age 34, pregnant and with blood pressure of 175/115. Pressure continued at approximately this level for 15 months whereupon she had a renal calculus removed. There was the usual transitory fall associated with an operation. Six months later pressure rose to 260/150 where it remained until just before death a year later.

pressure is up and that their symptoms are due to this cause. Many hypertensives do not have any symptoms at all until some ill-advised physician alarms them by telling them their blood pressure is elevated and what dire consequences may befall them!

2. *Vasospastic symptoms:* Since essential hypertension is associated with constriction of the arterioles over the entire body, even in the absence of a psychoneurosis, it seems likely that symptoms may be produced solely by varying degrees of constriction or spasm. Yet it should be remembered that a blood pressure as high as 250-300 mm. systolic may exist for years without headache or other symptoms. Here we invoke the explanation that people vary in their sensitivity to disease processes. At any rate, we often find severe headaches, dizziness, nervous tension without basis, spells of flushing, etc., all of which may be intense and prolonged. Marked rises in blood pressure, with headaches, convulsion, and momentary pareses (hypertensive encephalopathy), are likely due to vascular spasm.

3. *Organic symptoms:* These symptoms develop when changes have occurred in

the brain, heart, and kidneys due to vascular changes. There may be symptoms referable to impairment of function in one or all of these organs. Usually, however, dyspnea on exertion is the first authentic symptom; this may go on to orthopnea and attacks of cardiac asthma (acute left ventricular failure). Palpitation may result from consciousness of the forceful beat of the heart or from extra systoles or other irregularities. Angina pectoria is common because of coronary sclerosis.

Cerebral symptoms include headache, dizziness, tinnitus, blurring of vision, aphasia, transient pareses, and hemiplegia or hemiparesis due to thrombosis or hemorrhage.

Renal symptoms are less prominent than cerebral or cardiac symptoms. Frequency and nocturia, due to voiding of larger quantities of low specific gravity urine, may be noted. In those cases which go on to uremia there is progressive drowsiness, weakness, gastrointestinal disturbances and, finally, coma and death.

Frequent nosebleeds and subconjunctival hemorrhages occur in some hypertensive patients.

SIGNS

It is still uncertain whether degenerative changes in the arterioles and arteries of hypertensive patients are the cause or the result of the disease. In any case, the clinical picture en-

countered in hypertension is largely the result of these pathologic changes. They are manifested in the ocular fundi, the brain, the heart, the kidneys, and the peripheral arteries. Of course, in the early stages of the disease the physical examination reveals no abnormality.

The arterioles of the body, which are the vessels whose vasoconstriction is responsible for the raised blood pressure, can be seen in the fundus of the eye. They may show narrowing and, later, thickening and tortuosity. Hemorrhages, exudates, and papilledema are found at more advanced stages.

The cardiac changes occurring in hypertension consist of enlargement and coronary artery disease. The enlargement at first affects the left ventricle only; later the whole heart is enlarged. Systolic murmurs are common over the apex of such hearts.

Involvement of the kidneys is revealed by the appearance of albuminuria and loss of concentrating power. Large quantities of dilute urine may be passed; in the late stages urinary output falls and nitrogenous retention occurs.

Peripheral arteriosclerosis is readily felt by palpating such arteries as the radial or brachial. The vessels are thickened, hardened, and tortuous. The pulse may be of increased amplitude in earlier cases but becomes less as arterial damage increases.

TREATMENT

The rational treatment of any disease is a direct attack on its cause. But only rarely in hypertension is a removable etiological agent to be found. Surgical excision of a coarctation of the aorta, an adrenal tumor, or a unilaterally diseased kidney may result in cure when these unusual conditions are encountered. In the vast majority of hypertensives, however, there is no demonstrable cause and in these there is no specific remedy. Treatment thus is far from satisfactory, yet by palliative and symptomatic measures much can be done to increase their comfort and perhaps prolong their lives. Some

HYPERTENSION - SIMPLE PSYCHOTHERAPY

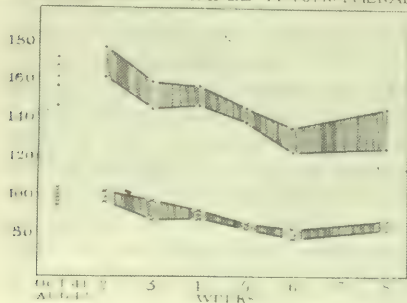


Fig. 4. Fall in blood pressure and complete disappearance of symptoms in a 42-year-old man interviewed at weekly intervals. He was given no medication except a placebo of raspberry syrup three times a day. (In this and subsequent graphs the width of curves represents the high and low readings during each period of observation.)

common therapies are as follows:

1. *Simple psychotherapy:* Most hypertensive patients respond in some measure to reassurance, explanation, and encouragement. They feel more secure when under the care of a sympathetic but enthusiastic physician. In particular, they benefit from the knowledge that the disease may exist for many years without doing them harm and may even disappear spontaneously in the course of time. A mild sedative such as phenobarbital further assists these patients to develop mental calm. The beneficial effect of many drugs, reputedly of value in treatment of hypertension, is due in most instances to these psychic effects rather than to the medication. This is illustrated in *Fig. 4*.

2. *Rest:* Adequate physical rest is of importance to the hypertensive. This includes rest periods during the day, sound sleep at night, and sufficiently long annual vacations. Best results are obtained when physical and mental relaxation are combined. Sometimes this requires removal from the tension of the business or domestic environment to the quiet and orderly routine which ought to prevail in hospital. This effect is shown in *Fig. 5*.

COMPOSITE CHART SHOWING EFFECT OF REST ON BLOOD PRESSURE

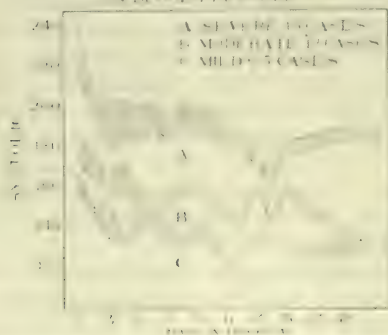


Fig. 5. Effect of rest in hospital on the systolic blood pressure of 50 hypertensive patients.

3. *Reduction in weight:* The obese hypertensive is usually much benefitted by weight reduction. Although the blood pressure may not fall appreciably, the burden on the heart is lessened and the patient always feels improved. Many diets have been recommended in the treatment of hypertension — their main value lies in the loss of weight by the obese and the restriction of salt in those

in whom heart failure threatens. A beneficial result is shown in *Fig. 6*.

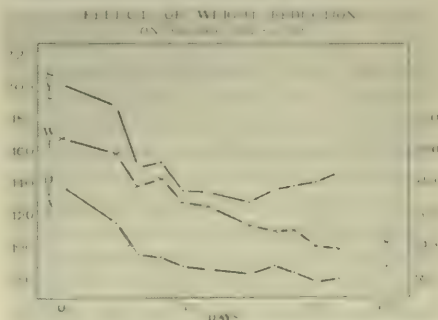


Fig. 6. Parallel reduction in weight and blood pressure in an obese man of 49. Some psychotherapy no doubt contributed to the effect although no conscious effort was made in this direction.

4. *Thiocyanate:* Most of the drugs used in hypertension depend on psychic effects; the most important exception is thiocyanate. This drug is capable of reducing blood pressure and relieving symptoms to a degree beyond that effected by placebo therapy⁴. This can be demonstrated by having patients alternately on and off thiocyanate without their knowledge so that the psychic factor is controlled. *Fig. 7* illustrates repeated falls in blood pressure when thiocyanate was given, followed by rises in pressure when a placebo mixture of similar color and taste was substituted.

Although useful in selected cases, thiocyanate has not a wide application

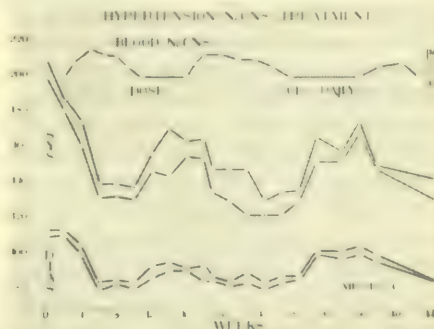


Fig. 7. Effect of thiocyanate on blood pressure. The top curve represents the blood level of the drug; the middle and lower curves the systolic and diastolic pressures respectively. Where blood pressure curves are hatched, the drug was being given; where the curves are plain, the placebo was administered.

because it is toxic and dosage must be carefully controlled by periodic estimation of the level of the drug in the blood. It is contraindicated in the presence of lowered renal function or advanced coronary or cerebral arteriosclerosis. However, patients with severe headaches and high pressure are sometimes much relieved by its use.

5. *Sympathectomy*: During the past 25 years there has been much interest in the surgical treatment of hypertension by removing portions of the sympathetic nervous system. Many of the earlier reports were overly enthusiastic and the operation thereby discredited. There is now no longer any doubt that it is of value in a few properly selected cases. It should be considered in severe progressive hypertension, especially in patients below the age of 50. A good effect is shown in Fig. 8.

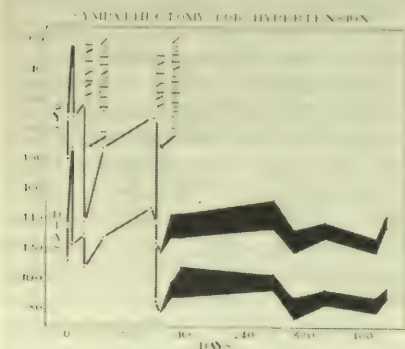


Fig. 8. Effect of sympathectomy in a woman aged 23 known to be hypertensive for two years. Note that blood pressure fell strikingly with the sodium amytal test which is often used in selection of suitable cases for operation. (Operation by Dr. H.F. Cameron)

PROGNOSIS

The course of essential hypertension is extremely variable but commonly lasts from 10 to 20 years. Though usually associated with a slow progressive degeneration of the arteriolar system, long remissions may occur for no apparent reason and occasionally these are permanent. Unfortunately, as already pointed out, the disease sometimes behaves in the opposite manner and runs a rapid and destructive course.

It is important that all those participating in the management of hypertensive patients realize that prognosis is not dependent on the height of the blood pressure alone. Some patients tolerate very high pressure for many years with little ill effect, while others suffer serious disability after only a few years of moderate elevation. It is for this reason that it is desirable to educate patients away from reliance on their actual blood pressure figures.

Elevation of blood pressure is one of the commonest signs met with in clinical medicine. If the diastolic pressure is persistently raised when taken repeatedly under resting conditions, a thorough search for an underlying cause must be made. Usually none is found and a diagnosis of essential hypertension can be established. It is then necessary to determine to what extent, if any, the arterioles and vital organs (heart, brain, kidneys) have been damaged. Review of these from time to time indicates whether or not the disease is progressive. The course of the disease is favorably influenced by several simple measures as well as by certain medical and surgical treatments. In particular, both doctor and nurse can contribute much to the welfare of the patient through encouragement and reassurance. An attitude of calm optimism, supplemented by a simple statement of fact, can do much to allay the patient's fears. Fortunately, the usual benign course of the disease justifies this approach.

Acknowledgement: Thanks are due to Miss G. Dubo for preparation of the graphs.

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Nursing the Hypertensive

MARGRET SIGMUNDSON and CLARA EINARSON

Average reading time — 11 min. 48 sec.

HYPERTENSION, the commonest and most important of all heart diseases, causes more deaths than cancer and tuberculosis combined. Six people out of ten, reaching the age of 65 in good health, will die from diseases that are associated with high blood pressure.

There are two types of hypertension, namely—benign and malignant. The malignant variety is of relatively short duration, the average prognosis being about two years from the time of the first symptom. It is characteristic in its rapidly fatal course, its protean manifestations with signs and symptoms of damaged retina, faulty kidney function, generalized arterial spasm, and rapidly enlarging heart. Eighty per cent of cases occur in people under 45.

Because of the nature of the disease and the necessity of extensive laboratory and x-ray procedures to evaluate a case suitable for therapy, the treatment of malignant hypertension is always a hospital procedure. A treatment for this condition, brought to the front within the last decade, is the lumbodorsal sympathectomy as devised by Peet, Smithwick, and others.

In contrast to this is the disease of benign hypertension occurring in an older age group, lasting many years and rarely resulting in the inevitable outcome of malignant hypertension. Benign hypertension, nearly always associated with arteriosclerosis, produces fatal complications in the form of cerebral or coronary artery thrombosis.

THIOCYANATE

In more recent years the treatment

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of the disease with sodium thiocyanate has been introduced and received considerable attention. The action of sodium thiocyanate is not altogether understood but it is known that the drug is a powerful, protoplasmic poison and, as such, may produce toxic effects. These largely consist of anorexia, nausea and vomiting, erythematous dermatitis, and changes in bone marrow.

The dosage necessary to maintain effective blood concentration varies. Blood levels must be done weekly until the maintenance dose has been ascertained. Monthly levels must be continued, due to the occasional case with a long interval between the first administration and the signs of toxicity. If the treatment with sodium thiocyanate is to be followed, important considerations are: a complete clinical and laboratory assessment of the patient, administration of the drug as ordered, and some knowledge of its toxicity. It is evident that the nurse, with her more constant association with the patient, must be aware of the toxic effects and watch for any symptoms.

THE NURSE'S PART

The nurse plays an important role in the treatment of any patient with hypertension. It is she who aids the patient in attaining the proper mental attitude toward his illness by providing pleasant, peaceful surroundings, cheerful atmosphere, and repeated reassurance regarding his condition. While he is in hospital, the nurse must use every opportunity to help the patient adapt his life to his disease, without stressing his illness to the point where he considers himself a permanent invalid. It should be pointed out that he may lead a long and useful life provided he avoids all excesses. Moderation in exercise, eating, drinking, and smoking; freedom

from worry; rest and complete relaxation are the prime factors to be considered.

When he first hears of all these restrictions, the patient is likely to become depressed and discouraged, and needs detailed explanations as to just what each one implies.

1. *Freedom from worry*, the most important item, is one of the most difficult to secure. The patient is concerned with his own welfare, with being a burden upon others and, in the case of most family men, with financial worries. He should be told how many persons, in the same predicament, have been able to adjust their work so that they could carry on a relatively normal business life. The necessity of avoiding all emotional strain, such as excitement, fear, and tension, must be equally emphasized.

2. *Rest*, which is always stressed so much in hospital, must become part of the daily routine. The patient should be taught the value of resting a half-hour or more after each meal and, if possible, lying down in complete relaxation for at least an hour every afternoon. Adequate sleep is essential to the patient's well-being, eight to ten hours being the minimum requirement.

3. The education of the individual as to the *kind and amount of exercise* he may take is important. Although his activities must of necessity be curtailed to some extent, reasonable exercise is beneficial. The amount of exercise advisable is best regulated by the patient's own tolerance for it.

4. *Proper diet* is essential. Frequent light meals are preferable to three heavy meals per day. The obese patient benefits greatly by a reduction in weight with a general limitation in diet. All patients with hypertension need to limit their meat consumption but plenty of fresh fruit and vegetables are desirable as these tend to combat constipation.

- 5: *The use of alcohol and tobacco* should be limited but it is unnecessary to advise complete abstinence. This only causes undue strain on the patient and is then likely to be disregarded.

6. *Recreation* is a necessary part of everyone's life and is of vital importance to the hypertensive. Sports or hobbies requiring a moderate amount of exercise

provide relaxation and prevent the patient from considering himself an invalid, unable to partake of the activities of normal people.

It is equally important that the family be made to realize the necessity and reason for all these restrictions, that they may supplement the efforts of the nurse in gaining the patient's cooperation. Upon the patient's discharge from hospital, the family must assume the responsibility of helping him to adjust to his modified regime. Only when they comprehend the nature of the disease and its inherent dangers are they able to do so.

CASE HISTORY

Mr. Lee, a 65-year-old retired railway man, with benign hypertension, had been attending the out-patient department for several years with complaints of dyspnea on exertion and swelling of the ankles by the end of the day. In addition to this, he was aware of increasingly severe and frequent headaches and dizzy spells. By this time, his blood pressure was 210/110 and he was admitted to hospital for investigation and treatment of his symptoms.

Mr. Lee was a heavy-set, red-faced, white-haired man. He was a cooperative patient, cheerfully complying with all restrictions of exercise, excitement, and diet. He showed an intelligent interest in and understanding of his condition.

For the first three weeks in hospital, treatment consisted of bed rest and mild sedation in the form of phenobarb. gr. $\frac{1}{2}$ t.i.d. On this, he showed considerable subjective improvement although there was little change in blood pressure. In view of this, sodium thiocyanate treatment was considered and the necessary laboratory tests done to determine whether or not he was a suitable candidate. Urea clearance showed a mean function of 48%; specific gravity of urine in urine concentration test was 1.020. Electrocardiogram revealed left ventricular strain.

For two weeks Mr. Lee was given to believe that treatment had been started whereas he received a placebo medication which had the appearance and taste of the actual drug. This was done to determine the extent of any psychological

effect the medication might have. Mr. Lee showed no appreciable change in condition throughout the test period. By the end of the first week on sodium thiocyanate he was nauseated and felt weak so the dose was reduced and all toxic symptoms disappeared. He continued on sodium thiocyanate, phenobarb., and limited exercise for a month.

Because of his cheerful, optimistic nature, nursing care was minimized. Although he was confined to bed most of the day, Mr. Lee kept himself occupied and content with his leatherwork, which had long been his hobby, and the ever-present detective novels supplied by the hospital library. He was given a light ward diet with milk and biscuits between meals. As in the case of all cardiacs, the care of the bowels was important, it being necessary to avoid the dangers resulting from constipation and straining at stool. In view of this, he was given mild purgatives or a saline enema every third day. Frequent care of his back was given to prevent the pressure sores which may occur in an elderly patient on bed rest. Throughout the course of treatment, daily blood pressure readings were taken and showed a decrease from 210/110 to 175/95. When he left hospital two months from the time of admission, Mr. Lee "felt like a new man." He was instructed to report to the out-patient department so that treatment could be continued and followed.

SYMPATHECTOMY

The nursing problem for a case selected for sympathectomy is quite different in form. The general measures are equally as important as the medically treated case, if the patient's hypertension is to be evaluated. Pre-operatively, several laboratory tests, including the blood urea nitrogen, urea clearance, and urine concentration are done to determine the extent of the renal impairment. In the urine concentration test, fluids must be restricted from 4:00 p.m. until the specimens are collected at 6:00 a.m. and 7:00 a.m. Similarly, the entire value of the urea clearance is dependent upon the time and the amount of urine passed. In an effort to determine the lability of the blood

pressure and, indirectly, the suitability of patient for operation, the sodium amytal depressor test may be done. To obtain optimum results, the patient must be at rest mentally and physically and the surroundings be as quiet as possible. It is the nurse who is in large part responsible for the accuracy of these tests.

CASE HISTORY

Mr. Stein, a 37-year-old Jewish immigrant from Germany, was admitted to hospital for investigation and treatment of his headaches. He complained of severe, penetrating, occipital headaches, recurrent nosebleeds, and blurring vision for the past three months.

Physical findings revealed a blood pressure of 210/140, a markedly enlarged heart, and grossly abnormal eye-grounds with swollen discs, arterial spasm, patches of exudate both old and new, and enlarged retinal veins. Sodium amytal sedation test revealed a drop in blood pressure from 210/120 to 115/80. Further investigation showed a urine concentration of 1.024 and a blood urea nitrogen of 18 mg. %.

It was thought that Mr. Stein might well benefit from a lumbodorsal sympathectomy. After some discussion and consultation with the family, he consented to surgery.

Mr. Stein was a nervous, apprehensive individual, constantly worrying about the state of his health. His family was unable to improve his mental attitude. They were equally as worried and excited over his condition and required as much reassurance as the patient himself. On several occasions, after visiting hours, Mr. Stein was seen aimlessly pacing the corridor in a state of agitation. Given the opportunity to talk about himself, his condition, and the treatment he was to receive, he became more relaxed.

In the course of his investigation, it was discovered that his hemoglobin was only 62%. He was given two blood transfusions pre-operatively, bringing it up to 76%. The operation performed was a right lumbodorsal sympathectomy, entailing the removal of nerve and ganglion tissue from T5 to L4. His immediate post-operative condition was satisfactory. Routine orders, consisting of active and

passive movements, deep breathing, and change of position, were carried out. Demerol 100 mg. was given p.r.n. for pain. Fluids were encouraged and intravenous fluids given to supplement his oral intake for the first few days. Blood pressure was taken frequently and was found to fluctuate between 244/144 and 188/105. Mr. Stein continued to improve steadily and, before long, had increased his activities from dangling to walking about the ward. Chest plate prior to discharge revealed a pleural effusion, one of the commonest complications of sympathectomies. He was discharged eleven days after operation with a blood pressure of 218/118.

Three weeks later Mr. Stein was readmitted for the second stage of his sympathectomy. He was not as nervous or apprehensive as on his previous admission. Chest plate showed the pleural effusion to be resolving. He was slated for surgery three days later when a left lumbodorsal sympathectomy, with the removal of nerve and ganglion tissue from T6 to L4, was done. Post-operative treatment was primarily the same as for his first operation. At times he was very apprehensive and required a great deal of

reassurance. On the third post-operative day he was allowed up but, before getting up, a scultetus binder was applied and elastocrepe bandages to both legs. Exercise tolerance was rapidly increased and the post-operative course was uneventful. On discharge his blood pressure was 165/100 and symptomatic results were excellent.

As shown by the very satisfactory results obtained in these two cases, it is evident that much can be done to relieve the suffering of the hypertensive patient.

Although these are only two of the many treatments used in the treatment of hypertension, they have been found to give the most satisfactory results in selected cases. Many patients are benefitted by simpler measures.

The nation is rapidly becoming more health conscious. It is to be hoped that, through routine physical examinations, diagnosis will be made earlier, for success in therapy is dependent on treatment being initiated before vital organs are too severely damaged.

Public Health Nurse's Role with the Hypertensive

SUZANNE PETURSSON

Average reading time — 5 min. 12 sec.

WHEN WE REALIZE that 25 per cent of all people who die after the age of 50, die as a result of the effect of hypertension, we can see that the disease constitutes a major public health problem.

The public health nurse thinks of the disease in two aspects—first, the hypertension which has not progressed to the point where it has produced serious organic changes in the body; and, second, hypertension which is well established and has markedly

damaged the arteries, kidneys, and more frequently the heart.

In working with patients suffering from the disease the public health nurse gives nursing care in the home where necessary. Of equal importance is a service which is often overlooked. This is the help which she may give the patient and his family in adapting the home situation to provide rest and freedom from anxiety for the patient while, at the same time, she tries to restore him to his greatest economic efficiency. This seems like a large undertaking but is very essential when we realize that lack of care may

Mrs. Petursson is a staff member of the Victorian Order of Nurses in Winnipeg.

result in death or chronic invalidism fairly early in life. With adequate treatment and a regime of moderate living the majority of patients tolerate hypertension fairly well.

In the other articles dealing with this topic, it has been shown how bed rest and the removal of the patient from a distressing home atmosphere usually decrease the blood pressure. Conversely, a patient's condition may deteriorate if, after dismissal from hospital, he returns to a home where he is overworked and under pressure of mental stress.

Cooperation between the doctor, nurse, and patient's family is necessary to determine to what degree the patient must moderate his life. The nurse needs instruction from the physician as to the gravity of the patient's condition and the extent to which he may resume former activity. The nurse, who is often more familiar with the patient's home situation and the existing community facilities which may offer aid, can cooperate with the family in assuring a proper regime for the patient.

To the patient this moderation of activity is usually distressing. Encouragement to rest must never be allowed to be interpreted as encouragement to idleness. Chronic illness carries with it a heavy toll of mental lassitude. The patient must be kept mentally and, as far as possible, physically active. It is of little value to attempt to increase a patient's life-span if he is to be made to feel a burden on his family and community.

The public health nurse hopes to find the hypertensive patients in her district soon after they are diagnosed and helps to make the period of adjustment easier for the patient and his family. The following case study will illustrate specifically what the nurse hopes to accomplish.

CASE HISTORY

In 1946, Mr. and Mrs. Bird, with their two youngest children, lived on a farm in rural Manitoba. At this time the heavy work appeared to be too much for Mrs. Bird who was now 49 years of age. The family sold their farm and moved to Win-

nipeg. Here Mr. Bird had difficulty in finding regular employment, so the family used their savings to buy a large rooming-house. This provided a small but regular income and the work of the household was largely Mrs. Bird's responsibility.

Since the birth of her youngest son nine years before Mrs. Bird had had no medical contact as there was neither a doctor nor health unit in their rural locality.

The Victorian Order nurse met Mrs. Bird when making a visit to one of the tenants in the rooming-house. She complained to the nurse that she had had a severe cold for a month, a cough that kept her awake at night, and shortness of breath. In addition, her ankles were edematous and she complained of a small urinary output.

The nurse suggested she visit the medical clinic for a physical examination and Mrs. Bird agreed to do so. Here she was diagnosed as hypertensive with cardiac involvement. Hospital care was advised and the nurse directed Mrs. Bird to a social agency which agreed to provide housekeeping service for her family during her period of hospitalization.

In hospital Mrs. Bird was treated with mercurials, thoracentesis, and bed rest. Before dismissal she was advised to report to the hypertension clinic every two weeks and the V.O.N. was requested to give Mrs. Bird 2 cc. salyrgan twice weekly at home.

On return from hospital she appeared much improved. She had lost 18 lb., her edema was less, she appeared more rested and was anxious to resume normal activity as soon as possible. The doctor had ordered a moderation of activity and when the situation was explained to Mr. Bird he wrote to an elder daughter who agreed to return home to assume some of the responsibility of the household. So as not to unduly alarm her regarding her illness, the nurse discussed ways of relieving Mrs. Bird of some of her household duties with the family.

Mrs. Bird was encouraged to continue any work which did not entail too much physical activity. She was taught to keep an accurate recording of her weight and to lessen her fluid intake. The doctor had advised a reduction in weight and

the nurse gave Mrs. Bird a table of caloric values and suggested food substitutions to make her diet more palatable. Through the past three years Mrs. Bird has occasionally needed to be readmitted to hospital for complete bed rest for periods of approximately 10 days. This was due to a more marked increase in blood pressure. It is interesting to note that these periods occurred at times of strain in her family life—during the illness of a son, during long periods of unemployment of her husband.

Prolonged treatment and these periods of hospitalization resulted in financial hardship for the family. The nurse directed the family to the city Social Welfare Agency which agreed to provide Mrs. Bird's medication free of charge and pay part of the cost of her hospital care. It can be seen that much remains

to be done in the public health field. There is a great need for expanding diagnostic and treatment facilities in rural areas. The benefits received by the individual and the state, through early diagnosis of potentially chronic diseases, are substantial. For this reason regular physical examinations should be made available to all.

The greatest difficulty the public health nurse meets in working with hypertensive patients is finding these patients early. The service which she can offer in the home is not often recognized until the patient actually needs bedside care. It is hoped that the day will soon come when doctors and patients will call her early so that she may give more adequate care and so help to rehabilitate the hypertensive patient with little delay.

Who is Responsible?

AGNES J. MACLEOD

Average reading time — 4 min. 6 sec.

SO OFTEN I hear the statement "Why doesn't someone do something about it?" or "What is the C.N.A. doing about this?" or "What is the provincial nurses' association doing about that?"

I would like to discuss briefly a very important professional problem which is facing every nurse earning her livelihood in the practice of nursing in Canada. Who should evaluate and accredit our Canadian schools of nursing?

Each one of us graduated from some one school of nursing. If we are honest, thinking individuals, we must all admit that there were some things wrong with our professional nurse preparation. No school in Canada, which is conducted by one hospital, has yet been able to give to its student nurses sufficiently planned, integra-

ted, broad or complete nursing educational programs to satisfy fully the criteria for professional education.

Certain faults of schools of nursing stand out more starkly than others. For one reason or other, hospital boards, school of nursing committees, hospital medical and nursing administrators, as well as directors of schools of nursing and instructional nursing staffs, continue to cling to the old order, glorify their particular traditions, and deplore any departure from the present hospital-controlled school of nursing tie-up which exists across our country.

Graduate nurses themselves are too complacent and, through lack of awareness or lack of interest, as well as preoccupation with their personal affairs, neglect their professional obligations and seem to think that it is someone else's concern that our present system of nurse training is not providing sufficient well-trained nurses to meet the health service needs of Canada. For years the few conscien-

As chairman of the C.N.A. Educational Policy Committee, Miss Macleod has taken a very active interest in sponsoring this vital program.

tious nurses have carried the load for the many. Yet, because of the complacency of the many, the few are not able to achieve all the reforms that are needed to improve our schools of nursing.

Canadian schools of nursing need to be evaluated and accredited. Yet, because of lack of large enough affiliation fees to the C.N.A. from every nurse working in this country, the Canadian Nurses' Association, although recognizing the need for accreditation, has not been able to finance such an undertaking so far.

Now that our demonstration school—the Metropolitan School of Nursing in Windsor—has graduated its first class of students in 25 months, it is imperative that Canadian nurses at least have an opinion as to whether this new principle of nursing education—"that nurses can be better prepared in a shorter period of time, in a controlled educational situation"—is sound or not. Many experienced nurse educators believe it is sound.

But we need a system of evaluation, whereby all schools of nursing can be judged and helped to improve their present deficiencies. Later, in fact one educator claims it would take six or seven years, we need to establish a system of accreditation for schools of nursing. Poor schools should not be allowed to continue indefinitely.

What is being done in Canada to bring about such an Evaluation and Accreditation program? To answer that question, our editor requested me to write this article as the final one of the series dealing with Evaluation and Accreditation appearing in *The Canadian Nurse* this spring. If, by chance, you have missed these articles, I would suggest that it is the *responsibility of every nurse in Canada to know* what has already been done along these lines in Canada and the United States. I would refer you to your *Canadian Nurse* for:

1. February, 1950, page 112. Editorial: Evaluation of Schools of Nursing.
2. March, 1950, page 187. Margaret M. Street: Accreditation of Educational Programs in Nursing.
3. April, 1950, page 278. Sr. Denise

Lefebvre: Evaluation of Schools of Nursing.

In this last article you will see how far the Nursing Sisterhoods of the Canadian Conference of Catholic Schools of Nursing have progressed.

During this biennium, the C.N.A. Committee on Educational Policy has studied the problem of how we can best institute a program of evaluation and later establish an accreditation system for Canadian schools of nursing. In order to secure advice and knowledge on how we should proceed, Miss Margaret Street was appointed convener of a small sub-Committee on Evaluation which has met several times. The members of this sub-committee are acting as the nurse consultants for the Work Conference on Evaluation and Accreditation of Schools of Nursing at the C.N.A. Convention this summer. Sister Denise Lefebvre, s.g.m., M.Sc., is a nurse educator of distinction and is considered a real authority on this subject by everyone who knows her. We are fortunate to have her as the chief consultant at the work conference. It is hoped that everyone registering for this work conference will enter into the program whole-heartedly.

We believe that before the Canadian Nurses' Association can launch an evaluation program there must be another person at National Office whose responsibility it would be to travel, arrange, and conduct area institutes on, and eventually help set up the machinery for such an evaluation program. Consequently, the Executive Committee accepted the recommendation for discussion and decision at the meetings in Vancouver—that an educational secretary should be appointed to National Office. *It is your responsibility to vote on this resolution in June.*

If the C.N.A. decides to appoint an educational secretary, we will hope that before long our national evaluation program can be initiated.

The Hawaiian alphabet consists of only 12 letters—less than any other language in the world.

Nursing Profiles

Laura Holland, C.B.E., R.R.C., can now add another impressive set of initials to her name. At the annual convocation of the University of British Columbia on May 12, Miss Holland received the honorary degree of Doctor of Laws in recognition of the outstanding contributions she has made in the social welfare field. Best known for her service in this area, it is, nevertheless, a matter of pride to the nurses of Canada that she has never been too busy nor too engrossed in her social work activities to participate actively in professional nursing affairs. Thus we echo the congratulations of our social work colleagues in acclaiming Miss Holland.

Born in Montreal, Miss Holland deserted a promising musical career to enter the school of nursing of the Montreal General Hospital where she graduated in 1914. After a year in private nursing, she joined the C.A.M.C. and served with distinction in England, France, Salonika, and Lemnos.

Returning home, Miss Holland decided to broaden her training by studying social work at Simmons College, Boston. After a year as social worker in the V.D. clinic at M.G.H. she became director of nursing services with the Ontario Red Cross Society. In 1923, she became manager of the Welfare Division of the Toronto Department of Public Health. She moved to Vancouver four

years later to undertake the re-organization of the Children's Aid Society. Her field of influence was broadened in 1931 when she took over the functions of the superintendent of Neglected Children for the province. When she became supervisor of the B.C. Welfare Field Service her far-seeing judgment enabled her to lay the strong foundation on which this service now functions. Immediately prior to her retirement in 1945, Miss Holland was adviser to the Minister on Matters of Social Welfare Policy.

Miss Holland's great gifts of knowledge, technical competence, and administrative skill have brought her public recognition. These would all have been barren if it had not been for her warmth of personality, her personal kindness and understanding, her spirit of altruism and her devotion. Her example will continue to shed a glow across both nursing and social work in the years to come.

Edna E. Andrews, a Manitoba-born nurse who saw front-line service during World War II, has been elevated to the top feminine medical post in the Canadian Army. As Matron-in-Chief, Royal Canadian Army Medical Corps, Major Andrews succeeds **Major (Principal Matron) Dorothy F. Ballantine** who has held the post since 1946.

Major Andrews graduated from the Saskatoon City Hospital in 1931. Later she undertook post-graduate studies at the Royal Victoria Hospital, Montreal. She enlisted with the R.C.A.M.C. in 1941. She was assistant matron at No. 6 Canadian General Hospital during the campaign in Northwest Europe. Later, she became Capt./Matron with No. 16 C.G.H. In 1945 she was made an Associate of the Royal Red Cross.

Following her return to Canada, Major Andrews served at the Calgary Military Hospital and with a detachment of the Northwest Highway System. From June, 1946, until her present appointment she was attached to the Toronto Military Hospital.

Evelyn Florence Matheson has been chosen to receive the Thomas Wall Scholarship awarded by the Canadian Nurses' Association on behalf of the British Common-



LAURA HOLLAND

wealth and Empire Nurses War Memorial Fund. Miss Matheson plans to enrol next autumn at Teachers College, Columbia University, New York, for post-graduate work in school of nursing administration.

Born in Pithapuram, South India, the daughter of a Baptist missionary, Miss Matheson came to Canada during her 'teens and secured her Bachelor of Arts in 1941 from Acadia University, Wolfville, N.S. She entered the school of nursing of the Toronto General Hospital, graduating in 1944. She went to work immediately at T.G.H. as medical float, assisting the night supervisor. At the end of a year she was made an assistant head nurse. Three years later, Miss Matheson decided to engage in private nursing for a time. In February, 1949, she joined the general floor duty staff at Sunnybrook (D.V.A.) Hospital, Toronto.



EVELYN MATHESON

Mildred Dobbs, who for over 38 years has been nurse-in-charge of the Lethbridge Isolation Hospital, has retired. A native of Gloucestershire, Miss Dobbs began her nursing career among the poor in English slums. The urge to come to Canada seized her after many conversations with Canadians and watching ships leave for the New World. She finally succumbed to the lure and arrived in Lethbridge in the autumn of 1911. She began working at the Isolation Hospital and has been there ever since with only five days' sick leave in all that time. Miss Dobbs has returned to her homeland twice but has never had a desire to go back there to live.

Tribute was paid to Miss Dobbs's long years of faithful and humanitarian service by the City Council on the occasion of her retirement. Her kindly and efficient care has

brought cheer, comfort, and healing to young and old who have been patients at that hospital. Miss Dobbs retires with the warm appreciation and good wishes of her fellow citizens.

Etta McLeay, who graduated from the Hamilton General Hospital in 1906, and who for 44 years has given devoted service to her patients, has retired. Miss McLeay went west in 1911 after several years of duty in the tuberculosis sanatorium in Hamilton. She opened and operated Harbor View, a private hospital in North Vancouver and later Chatham House Private Hospital in Vancouver. She plans to live in Ontario.

In Memoriam

Charlotte (Foster) Bean, who graduated from Royal Victoria Hospital, Montreal, in 1936, died on March 29, 1950, at New Mills, N.B., following a lengthy illness. Mrs. Bean was on the general nursing staff of the Ross Pavilion for several years prior to her marriage.

* * *

Caro Clark, who graduated from the Lady

Stanley Institute, Ottawa, died in Hamilton on March 31, 1950. She had been in ill health for about a year. Miss Clark had served as superintendent of nurses at the Mount Hamilton Hospital from the time of its opening in 1917 until her retirement in 1938.

* * *

Jessie Alexander Connal, R.R.C., who had served as nursing instructor at Calgary

General Hospital from 1920 until her retirement in 1948, died on April 5, 1950, in Calgary. A graduate of the Royal Infirmary, Glasgow, Miss Connal served overseas for six years with the British Expeditionary Force. She was twice mentioned in despatches and was awarded the Royal Red Cross medal for her services.

Jacqueline Phillips, a member of the 1951 class of Saskatoon City Hospital, was killed in the crash of a plane near Saskatoon on March 29, 1950.

* * *

Roe A. Spooner, who graduated many years ago from St. Luke's Hospital, Ottawa, died in Kingston, Ont., in April, 1950.

In The Good Old Days

(*The Canadian Nurse*, June 1910)

"There has been up to within very recent years little or no practical idealism in hospital planning . . . The great question to be considered is that a hospital is a 'living thing' which must be supple as well as graceful; it must be a means to an end rather than the end . . . Peculiarly, those who are building a hospital are not the final arbiters of the ultimate size to which this hospital will attain. Most men . . . have rigidly fixed ideas that their hospital shall not contain more than just as many beds as its ultimate capacity. They give no thought to the growth of towns; they give no thought to the fact that people are becoming more and more educated to the hospital idea . . . They give no thought to the fact that, when their institution is full and they are running to their utmost capacity at all times with more patients clamoring for admittance . . . this condition gives birth to a mushroom growth of badly planned and poorly constructed hospitals — a menace and a detriment to any growing community."

* * *

"Does the average medical practitioner do his duty to his faithful nurse? Does he properly appreciate the value of her assistance to him? Does he take the trouble to ascertain the amount of work she does and the time she spends in looking after the patients?"

"We hold a fixed opinion that it is the duty of the physician to know as far as possible what the nurse is doing. It is surprising what a nurse will frequently endure

while caring for her patients. The physicians should see to it that the strain in such cases will not be unreasonably prolonged. We do not propose to lay down a set of rules for the doctor. When, however, he has as his assistant a good nurse . . . he should show her some kindly consideration."

* * *

"An important event, not only in nursing circles, but in regard to the interests of the city of Toronto as a whole, has just taken place. The Board of Education has appointed Miss Lina L. Rogers . . . as supervising school nurse for Toronto. Two assistants have also been appointed — Miss Jamieson and Miss Robertson."

* * *

"In March several cases of smallpox occurred in Port Arthur, Ont., including a patient and a nurse from the new R.M. and G. Hospital, also the medical health officer, his daughter, and two members of another family. All have recovered."

* * *

"A pleasing and popular feature of the occasion (*graduation, R.V.H., Montreal*) was the presentation by Mr. Angus, on behalf of the Governors, of an R.V.H. graduate's badge to Miss Felter, thus making her an honorary graduate of the school. Miss Felter, although not an R.V.H. graduate, has had charge of the operating department for several years, and the badge was presented to her as a mark of appreciation of her work in the hospital. It is the first time such an honor has been conferred by the hospital."

Good Hearing Helps

Before a child is condemned for inattention at home and school, make sure his hearing and eyesight are up to par. Poor hearing,

particularly, is often mistaken for carelessness and even stupidity. Medical attention, rather than discipline, may be what he needs.

Institutional Nursing

Post-Anesthetic Recovery Rooms

ELVA HONEY, B.N.

Average reading time — 15 min. 24 sec.

ARE YOU THE SUPERVISOR or head nurse of a surgical ward? Perhaps you are the director of nursing in a general hospital. In either case you are all too familiar with the dilemma that can arise when, just at dinner-time, several patients return to the ward from the operating-room. The thought that went into planning nurses' hours off duty, meal-times, and preparing equipment in advance often seems of no avail when even just one of the operative cases requires emergency resuscitation, skilled personnel, and highly specialized equipment. Chaos arises when these essentials are not available at a moment's notice.

How can the ever-increasing number of surgical patients be ensured safe post-anesthetic care when there is a shortage of nurses and the cost of special equipment limits its supply?

What happens in many general hospitals today? Mr. Smith, who has had a lobectomy, is returning from the operating suite to his room at the other end of the hospital. Elevator service is slow. It is just noon and the staff are en route to the dining-room. Patients are going to and from the x-ray department. Medical students are hurrying to their next lecture. A group of visiting nurses is already in the elevator; chatting, they do not immediately hear "one side, please." Some have to step off the car to make room for the bed and those attending the patient. A transfusion is in progress and through all the delay the patient's need for oxygen is increas-

ing. Eventually he reaches his own ward.

Miss Jones, the nurse in charge, the only one with experience in caring for this type of operative, is doing her best to ensure that the four other post-operatives of the morning, as well as the remaining patients on the ward, are receiving the required care. She is overwhelmed with worry and work. More so now, as she discovers that Mr. Smith's transfusion has stopped. Obviously the needle became dislodged as he journeyed from the operating room. Something is wrong with the oxygen equipment, just when all possible care had been taken to have everything in readiness for Mr. Smith's return. That old-style, worn tent should have been replaced long ago but the new, convenient ones are so expensive.

Miss Jones calls the interne. He is in some far-off corner. Likewise, the anesthetist, still busy in the operating room, is too distant to be of immediate help to Mr. Smith. After a lapse of considerable time the interne appears, accompanied by the surgeon. They finally succeed in restoring order but not without further delay in obtaining oxygen equipment, transfusion apparatus, stimulants, and so on. As one can see, an avoidable delay has occurred which might easily have been fatal. Everyone wants to help but no one helps properly.

Difficulties, similar to those just related, arose during the war when field hospitals were frequently inundated with patients in serious hemorrhagic, neurogenic or traumatic shock. Here was only a small staff of doctors, nurses, and orderlies; specialized equipment was at a premium. The

Miss Honey is Montreal Area nursing consultant with the Department of Veterans Affairs.

medical authorities agreed that the obvious solution to the problem was to centralize personnel and materials. So came into being the "Resuscitation Ward," which proved to be one of the good things to come out of the war. Patients arriving at a Casualty Clearing Station, for instance, were often in such poor condition that immediate operation was out of the question. They were grouped in the large resuscitation ward (tent or room as the case might be) where pre-operative care was given. When the surgeon and anesthetist considered these patients ready for operation they were taken to the adjacent operating room or tent for surgery. This over, they were returned to the resuscitation ward where the small but expert staff did wonders with the limited equipment allotted a C.C.S. What was available was right at hand.

Does this give a clue as to how the present plan of post-anesthetic care of patients in hospitals could be improved? Yes, indeed! The idea of centralization remains unchanged even though the familiar setting of long rows of canvas stretchers, mounted on trestles crowded up and down a hospital tent, gives way to a well-equipped, well-organized ward now bearing the name *post-anesthetic recovery room*.

Ideally, this room is part of, or adjacent to, the operating suite, is near the blood bank and large enough to accommodate two beds for each operating theatre. One bed is for the patient about to be operated upon, the other for the patient whose operation is just completed. In this room are to be found drugs and apparatus required to meet the needs of any emergency resuscitation. The personnel assigned for duty in this department must have intensive training and concurrent actual experience in preventive and curative resuscitation measures in order to be thoroughly familiar with the various signs and symptoms of shock and anoxia and to know what to do to keep the physiologic functions—respiration and circulation—as nearly normal as possible.

The name post-anesthetic recovery

room is perhaps misleading for it is advantageous to have the patients brought to this ward pre-operatively as well. The nurse has an opportunity to observe the patient before he is under the influence of his pre-operative medication. While caring for him during this period she has an opportunity to study the patient as a person. Should there be any delay in the operating schedule, the doctor and the anesthetist are also able to observe the patient and make the desired change in orders for treatment and medication.

Post-operatively, the patient is returned to the P.A.R.R. in his own bed. The intravenous therapy continues, oxygen is given as necessary, and the patient's color, pulse, respiration, and blood pressure are observed constantly.

Let us look at the advantages of this plan. Mainly, they can be summed up under two headings—*safety* and *saving*: safety as it relates to the patient; saving as it applies to personnel, equipment, and time.

Relieved of all responsibilities other than giving immediate care to the patients going to and coming from the operating room, the experienced, well-trained staff of the recovery room can be depended upon to give the patient every attention. Requisites are at hand. No waiting for stimulants that have mysteriously disappeared from the ward just at the moment they are most needed! No more long delays at the elevator! Ward routine goes on without interruption and yesterday's operative patients receive the care which they require. Surely this is a safer and happier state of affairs than that which followed Mr. Smith's lobectomy.

Now, should anyone doubt the economy of a recovery room, let us suppose that immediately post-operatively seven patients, having had major operations, return to three of the hospital's surgical wards. These patients require constant attention, therefore seven nurses will be needed to remain with them until they can be safely left alone. This may take most of a day; certainly it will repre-



Post-anesthetic recovery room, Queen Mary Veterans' Hospital, Montreal.

sent many nurse-hours. Were these operatives returned to a ward especially prepared as a P.A.R.R. this wastage of nursing time would be avoided, since the task of supervising the immediate post-anesthetic care of patients is greatly simplified when they are placed in one rather than seven different rooms. Seldom would it be necessary to have more than two graduate nurses, with wide knowledge and experience in resuscitative measures, plus two or three well-trained assistants for a 10-bed recovery room.

Everyone will agree that less oxygen, suction apparatus, etc., is required to equip one room near the operating room than to meet the needs of several surgical wards scattered throughout the hospital. Those who are doubtful as to the saving this represents in dollars and cents, should remember that material assembled in the recovery room is not subjected to the hazards of being moved from place to place, down corridors, in and out of elevators. Also, they should not forget the fact that careful maintenance by the recovery room staff lengthens considerably the lifespan of expensive equipment.

The time saved by centralizing staff and equipment benefits the patient, the doctor, and the nursing

staff. Surgeons are spared the irritation of waiting for the patient to arrive in the theatre from the ward; the patient is already next door to the operating room. Minutes count when life is at stake. It goes without saying that a well-trained team, working calmly and with the necessary equipment, will save precious time and provide efficient resuscitation thus lowering the incidence of post-operative complication and prolonged stay in hospital for the patient. The saving in nurse-hours will ensure, among a host of other advantages, an enjoyable meal-hour for those like distracted Miss Jones, who doubtless never thought of her lunch the day Mr. Smith had his operation because of the dilemma which followed his return from the operating room.

Administrators, doctors, nurses, and patients in hospitals, where a post-anesthetic recovery room has been instituted, are quick to cite the merits of such a plan.

Dr. H. R. Griffith, in 1943, organized the first post-anesthetic recovery room in Montreal at the Homoeopathic Hospital. The success of his effort continues and even the responsibility of affording student nurses experience in this specialty is met.

They are rotated through it just as through any other clinical service.

At Queen Mary Veterans' Hospital, Montreal, the post-anesthetic recovery room has proven a real asset since its organization in 1946. The 10-bed suite, adjacent to the operating room, has been well furnished with all emergency equipment (see list below) and benefits by being merged with the sub-department of gas therapy. Therapeutic gas equipment is centralized near the recovery room, kept in excellent repair, and available to all parts of the hospital on a few moments' notice. These departments are regularly staffed by two graduate nurses, one senior gas-technician and his assistant, plus three nursing orderlies. One nurse is on duty 8:00 a.m.-4:00 p.m., the other 11:00 a.m.-7:00 p.m. Their allotted days off duty are taken over the week-end when only emergency operations are performed. The senior gas-technician is on duty 9:00 a.m.-5:00 p.m. and is relieved during his day off by his assistant. The nursing orderlies for the recovery room cover the three 8-hour shifts, day, evening, and night, and for days off they too are relieved by the assistant gas-technician, himself a trained nursing orderly. Should there be patients in the recovery room after 7:00 p.m., the evening float nurse

and the recovery room orderly care for them. Likewise the night float nurse and the 11:00 p.m.-7:00 a.m. orderly are available if needed. If there is an emergency operation during the evening or night and the patient's post-operative condition is satisfactory, he may be returned to his ward where the recovery room orderly will attend him under the supervision of the ward nurse. Otherwise he is taken to the recovery room for the special attention he may require.

Operative patients, accident and poisoning cases are treated in the recovery room at Queen Mary. Patients who have had a general anesthetic, a high special anesthetic, reconstructive surgery—for example, lengthy plastic and orthopedic work—in fact, all major operative cases, depending on the type of intervention and their physiological condition, are all given the benefit of the close attention of the staff of the recovery room where all resuscitative equipment is at hand.

Serious accident cases, belonging as they do to traumatic surgery, are brought directly to the recovery room on entering the hospital or in the event of a mishap occurring within the institution. Likewise, poisoning cases benefit by the immediate antidotal treatment of the well-trained staff.

The majority of patients remain in the recovery room only long enough to completely regain consciousness and a normal physiological state. Others, in view of the nature and extent of the surgery they have had—for example, intrathoracic and upper abdominal cases—require more complete care and a longer period of close supervision. Usually, however, the patients are back on their respective wards by 7:00 p.m. on the day of operation, having had the immediate post-operative transfusion, intravenous, and other resuscitative therapy which they may have required.

The records at Queen Mary Veterans' Hospital show that 50 per cent of the operative patients receive post-anesthetic care in the recovery room



Using the individual irrigator stand.

although their pre-operative medications are still being administered on the ward, a custom which is not ideal. Patients having had low spinal anesthetic, if their general condition permits, are returned directly from the operating theatre to their respective wards, since they are fully conscious. Statistics at this institution indicate that, following the inception of the recovery room, the operative mortality rate diminished, respiratory complications became less numerous, and poor-risk surgical cases were undertaken with greater success.

DRUGS

Penicillin, neo-synephrine, prostigmine, vitamin K, amyl nitrate, metycaine, coramine, vitamin B, ascorbic acid (vit. C), caffeine sodium benzoate, solution of heparin, sodium pentothal, procaine, amp. of sterile water, ephedrine gr. $\frac{1}{2}$, pitressin, insulin, adrenalin, A.P.C. & C. sodium luminal gr. II, methedrine 30 mg. antistine 1 gm., digoxin 5 mg., ephedrine gr. $\frac{3}{4}$, metrazol 1 gm., thiamin chloride, sulfanilamide crystals, sulfadiazine sol., nembutal gr. $7\frac{1}{2}$ for I.V. use, aminophylline 25 gm., amp. of sterile normal saline, picrotoxin sol., sodium amytal $7/12$ gr., soda bicarbonate, potassium permanganate, sterilized amp. of 50% glucose, nupercainal ointment, narcotics drawn from adjoining surgical ward.

EQUIPMENT

Three heavy duty suction pumps—Ingram & Bell; 5 airways anesthetic; 1 apparatus gas anesthetic—Heidbrink; 13 catheters; 1 flashlight; 1 forceps, thumb 6"; 2 forceps—Jones (similar); 1 forceps—Halstead Mosquito 5"; 2 forceps, tongue—Collins; 1 forceps—Magill; 1 forceps, tonsil—Seizing 9"; 1 gag, mouth—Doyan; 1 laryngoscope; 2 stethoscopes—Douglas; 2 sphygmomanometer—Mercurial; 1 bulb irrigating syringe 4 oz.; 2 trays, instrument, 8" x 4" x 2"; 1 tray, catheter; 1 forceps, uterine serrated jaw; 1 hone carborundum; 1 safety razor; 12 arm-boards (padded and plastic-covered); 1 stomach tray (complete); 1 pneophore (artificial respirator); 4 sterile dressing containers; 1 tourniquet—Esmarch; 8 2-cc. syringes; 2 10-cc. syringes; 2 20-cc. syringes; 1 insulin syringe; hypo and in-



Close-up of irrigator stand.

travenous needles; 3 small tourniquets; 2 plasma sets; 2 intravenous sets; 3 blood transfusion sets; 2 "Y" for blood transfusion; 1 cut-down set; 2 restraining jackets; 4 tanks of oxygen equipped with meter and mask (pressure); 1 tank of carbon dioxide and oxygen equipped with meter and mask; 3 intratracheal tubes; 2 thermometers; complete stock of intravenous fluids and plasma; 8 linen straps for restraining patient.

FURNITURE

1 hospital bed, 1 desk, 9 bedside tables, 1 bed screen, 1 dressing carriage, 1 instrument cabinet (large), 6 irrigator stands (adjustable), 3 irrigator stands (portable), 1 instrument sterilizer, 1 medicine cupboard, 1 cupboard (large) for supplies, 7 kidney basins, 4 stands for raising foot of bed, linen and surgical supplies.

Conclusion: From the foregoing it will be noted that the ideal plan for applying the principle of centralizing hospital personnel and equipment to give safer care to patients requiring resuscitative care has been cited and that a concrete example of how a recovery room functions has been described. Many will appreciate the well-founded basis for the ideas regarding the post-anesthetic recovery room but will consider it too costly. Dr. Louis Lamoureux, adviser in anesthesia to the Director General, Treatment Services, Department of Veterans Affairs, has said: "Today, in

medicine, there are advances which we do not have the right to ignore, for these are in the interest of better

treatment to our patients and to the evolution and future of medical science."

Health Week Project

A comprehensive two-day program of lectures, films, and displays was sponsored by the Regina Grey Nuns' School of Nursing on January 30 and 31, 1950, in co-operation with National Health Week. The program was planned to cover various aspects of the health education field. The project was directed by Sr. A. Levasseur, educational director of the school of nursing.

One of the highlights was a display of health education posters and literature. The display was made up of eight booths, one relating to each of the topics covered. Student nurses were on duty in the booths at each session. Many of the guests took advantage of the literature provided, which was obtained from several sources such as: the Health League of Canada, the Health Education Division of the Saskatchewan Department of Public Health, and from other agencies concerned with disease and accident prevention. Some of the posters were made by students of the school of nursing.



Some of the booths

Addresses were given at each of the sessions by guest speakers from the Department of Public Health or from the hospital interne staff. Instructors conducted groups of students in panel discussion and symposia.

Speakers and their topics were as follows: Dr. E. Hornstein, "A National Health Program"; Miss D. Hagar, nutritionist,

Saskatchewan Department of Public Health, "Some Aspects of Modern Nutrition"; Dr. O. G. Burns, "The Expectant Father"; Dr. G. Bray, "The Common Cold"; Dr. D. Thompson, "Child's Health"; Dr. R. T. Hosie, "Prevention of Diseases"; Dr. W. MacDiarmid, "The Importance of Preventing Accidents"; Miss O. H. Anderson, director of health education, Saskatchewan



A panel group

Department of Public Health, "The Need of Health Education."

Discussion participants included: Miss M. Howell, health nurse; Miss J. Butterfield, dietitian; Miss D. Martin, assistant supervisor, obstetrical department; Miss F. Hummason, basic science instructor; Mrs. N. Street, science instructor. Students from all classes took part. A film pertaining to the topic under discussion was shown at each session.

Others who took part were: Miss M. Crawford, who made the opening remarks at each session; Miss B. Fay of the pediatrics department, who introduced the speaker on "Child's Health"; Mrs. A. O'Shaughnessy, medical clinical instructor, who introduced the speaker on prevention of diseases. Miss Anderson expressed the interest of her department in such projects and commended everyone for their interest and effort.

Each session was well attended. Students from collegiates in the city, Sisters, internes, graduate nursing staff, employees of the hospital, and students of the school of nursing were among those present.

A good diagnostician is always a pessimist: he looks for the worst.

Public Health Nursing

Public Health Nursing in Newfoundland

ELIZABETH R. SUMMERS

Average reading time — 9 min. 12 sec.

WE WERE very pleased indeed to receive an invitation to write about public health nursing in Newfoundland for *The Canadian Nurse* and we are glad of the opportunity of letting the rest of Canada know what we are doing here in that field.

In comparison with the other provinces, public health nursing in Newfoundland may be said to be in its infancy. None the less, we feel that within the past twelve years we have progressed so that now we can say that we have an organization to which we may point with pride. At the same time, we hasten to add that we are well aware of our many deficiencies and are constantly endeavoring to augment and improve the service.

Actually, we have too big a job for the available nurses. In this, of course, we are not unlike many of our sister provinces. However, our biggest problem, transportation, places us in a different category.

The island of Newfoundland is mostly settled along the coast-line which, as can be readily seen from any map of the Island, is heavily indented with numerous bays of varying sizes. Many of these settlements are cut off from one another except by sea, which is not always favorable for travelling by small boats. Thus it may be understood that while a given area serviced by a district nurse may look comparatively small, at the best of times she has difficulty covering it with satisfaction. Then, too, many places are without the services of a nurse at all.

Miss Summers is educational director with the Department of Health, St. John's, Newfoundland.

Perhaps a short account of the history of public health nursing here would be of interest at this point.

HISTORY

Up to 1920 there was no organized nursing in Newfoundland outside of the hospitals and those who did private nursing. At this time district nursing began under the auspices of "Nonia" (Newfoundland Outport Nursing and Industrial Association) which started with two nurses. In 1934, when the government took over the Nonia Nursing Centres, there were six or seven of them. New outport centres were then set up and a city service was started in St. John's mainly to provide care for the poor and to improve maternal and infant health.

In 1937 a Division of Public Health Nursing was started under the direction of Miss Syretha Squires (now Mrs. Scott Milley). These services were amalgamated in 1940 when it was considered that much of the work being done was overlapping. Since then the nursing service has expanded at a great rate. At the present time a considerable proportion of the population has available care both curative and preventive, through the Department of Health.

There are at present:

1. Fourteen cottage hospitals.
2. Twenty nursing districts (11 vacant).
3. Six nursing stations.
4. St. John's Unit (4 districts).

The cottage hospitals vary in bed capacity from 12-30 beds, depending on the population of the area served. There are two converted military hospitals—one each at Gander and

Botwood with a 50-bed capacity. Nursing duties are divided between two or three nurses with ward aides for assistance.

Nursing stations are staffed by a district nurse, a ward aide, and a cook. They are set up with two to four beds for emergency care, such as when a district nurse has a difficult confinement to attend or for a patient who might need care while waiting for admission to hospital.

The district nurse carries out a service consisting of a generalized nursing program, which includes more than is usually required of a nurse due to there being in most cases no doctor available. Advice and hospitalization are sought from the nearest hospital or doctor if there is one within reasonable distance. Otherwise, the Department of Health is notified and, on occasion, a plane is sent to her assistance.

St. John's district also carries out a generalized nursing service including:

1. Morbidity service—communicable and non-communicable diseases.
2. Maternal and infant care.
3. General and specialized clinics.
4. Preschool and school health.
5. Health supervision and education for various groups.
6. Tuberculosis dispensary (with mobile x-ray unit).

One of our problems is lack of professional education. Although some of our nurses have taken public health courses, and there are others doing so at the present time, the majority must take up their duties after an orientation and staff training program of six months' duration at the St. John's headquarters. This must often be shortened due to the pressing need for nurses.

In spite of many difficulties, the public health picture shows marked improvement during recent years. The nursing service rightly may take credit for some of this. The infant death rate has been reduced although it is far from being low. The incidence of diphtheria, typhoid, and whooping cough is considerably less. While the known cases of tuberculosis still re-

veal infection in a comparatively high percentage of the population, much has been done in the field of case-finding and subsequent hospitalization of those whose disease indicates the best chance of being arrested. Home visiting of tuberculosis patients and their contacts constitutes a vital part of our program.

Public health nursing presents a real challenge such as perhaps is found in no other province. For a nurse who is enthusiastic and who is prepared for any type of emergency as well as for the routine nursing problems, nursing in a cottage hospital or in a district provides satisfaction without compare.

While it is well known that diagnosis is outside the field of a nurse's duties, there are times and places where circumstances in Newfoundland demand of the district nurse at least tentative diagnosis and limited treatment for a variety of diseases. Though for emergencies and difficult cases assistance can be obtained, decision must also be made in many a situation where she would give anything to have a doctor close at hand.

In the outports, home confinements are the rule, the nurse and the resident midwife being always on call. The majority of small settlements have the services of a midwife who, if suitable, may undergo two months' training at government expense at a hospital in St. John's. She is then granted a licence to practise in a given area. No unlicensed midwife may practise in the same area. These midwives are under the supervision of the district nurse and must refer difficult cases to her.

Nursing in a cottage hospital means that the nurse is one of a small but vital unit, whose concern is the health of a designated community. This may be extensive and cover miles of coastline. While these hospitals are administered by the Department of Health, which at all times has its eye on preventive measures, it can generally be stated, however, that their main concern is curative rather than preventive. This is by no means through inclination; rather it de-

velops directly from the pressure of emergency and general medical and surgical work to be done.

The cottage hospitals have a resident doctor, a nurse-in-charge, and one or two staff nurses, depending on their bed capacity. The nurse-in-charge has to take over the responsibilities of everything—administering anesthetics, training ward aides, ordering supplies, housekeeping, and general supervision of the hospital. She is also on call for surgery and other emergencies alternating with the other nurses.

We have no unofficial or private organization in Newfoundland doing visiting nursing. As a consequence, our preventive program must take second place to bedside nursing in the home. The wonder is that some of the nurses find time for anything else.

We have a Child Welfare Association in St. John's which is doing invaluable work in infant health and welfare. They carry the whole pre-school immunization program, as well, for the Department of Health and

conduct general clinics with a medical officer of health. They have two Department of Health nurses on their staff. The Red Cross conducts well baby clinics at several centres. There is also one cottage hospital at Gander which has its well baby clinic.

Public health nursing is administered by the director of the Departmental Nursing Service, within the Department of Health, assisted by the supervisor of the St. John's staff and the field supervisor, who visits as many cottage hospitals and districts in a year as transportation permits. Staff education is carried out by the educational director. Health education on all levels is also part of the nursing service program.

In Newfoundland we have our own peculiar problems which we must work out accordingly, but we try to follow closely the progress of our more experienced sister organizations and have much to thank the Victorian Order of Nurses for Canada for in that our organization was patterned along their lines.

Nursing Sisters' Association

A Theatre Night was sponsored by the *Ottawa Unit* in March at the Little Theatre. Mrs. P. T. Sharpe was the convener for this project, assisted by Mmes P. J. Philpott, E. S. Perkin, and Miss G. Clark. The Ottawa Drama League Workshop presented "Payment Deferred" to a capacity audience. This performance greatly assisted the Unit in raising money for the Benevolent Fund.

Trafalgar House was the scene of a Fireside Hour when the executive of the unit entertained following the evening National Nurses' Vesper Service at St. John's Anglican Church held in May. The president, Evelyn Pepper, welcomed the guests who represented all branches of civilian nursing. Light refreshments were served, with J. Attwood as convener. A peppy sing-song concluded a successful evening.

Nurses Awarded Medals

Two nurses, who fought a diphtheria epidemic among Indians in northern British Columbia last winter, were recently presented with gold medals by two B.C. Cabinet ministers. Aileen Bond, of Kelowna, B.C., a graduate of St. Paul's Hospital, Vancouver, and Amy Wilson, of Calgary, Alta., a graduate of Calgary General Hospital, were honored for their part in fighting a diphtheria epidemic which raged through an Indian reservation in isolated Halway Valley.

The medals, centred by a diamond, were accompanied by parchments which read: "For outstanding courage—above and beyond the call of duty—an example of the co-operation between federal and provincial health services. A magnificent chapter in the development of public health nursing in Canada." (See News Notes, May issue, p. 407.)

Prevalence of heart disease rises with advancing age. Between ages 40 and 80 the rate about doubles every 10 years.

Aux Infirmières Canadiennes-Françaises

Le Travail Médico-Social

JACQUELINE GAGNON, B.Sc.H., M.S.S.

Average reading time — 15 min. 36 sec.

LA PROFESSION d'infirmière, comme d'ailleurs toutes les autres professions, a subi des modifications profondes depuis les 25 dernières années. Lorsqu'on se reporte, à ce que nous pourrions appeler l'enfance du nursing, on constate que le standard professionnel était loin d'être ce qu'il est aujourd'hui. Sans vouloir déprécier la valeur des pionnières dont la foi en l'avenir et le travail personnel furent grands, il nous est bien permis de constater que les exigences actuelles pour l'admission au cours de garde-malade et que les programmes d'études se sont haussés graduellement jusqu'à donner à l'infirmière graduée le statut d'une professionnelle authentique. Il y a lieu, me semble-t-il, d'applaudir à ces progrès, comme aussi de féliciter toutes celles qui ont le courage de s'astreindre à ces disciplines qui demandent tant de ténacité et d'abnégation.

Si excellente que soit la profession de garde-malade, il est incontestable que les progrès modernes et les obligations de la vie actuelle nécessitent une compétence sans cesse accrue de la part de celles qui veulent suivre véritablement le rythme des transformations qui bouleversent tous les milieux. C'est pourquoi, aux études régulières de la garde-malade, viennent s'ajouter, pour celles qui ont de l'enthousiasme et de l'idéal, des études complémentaires qui permettent d'accéder à des titres universitaires, aussi bien dans le domaine médical que dans le domaine social.

On se plaint, non sans raison, de la

pénurie d'infirmières, mais quel n'est pas le besoin de gardes-malades spécialisées en service social, en hygiène, en psychiatrie, etc. Nous espérons aider au recrutement pour l'une ou l'autre de ces spécialités en décrivant très brièvement les activités d'une infirmière dûment qualifiée et son rôle dans un service médico-social. Afin de mieux situer le problème, définissons tout d'abord les termes *service médico-social* et *travail d'équipe*.

Le *service médico-social* est un organisme destiné à aider le patient à résoudre les problèmes qui sont la conséquence immédiate de son état de malade, qu'il soit à domicile ou hospitalisé. La maladie, en effet, crée un état pathologique qui empêche celui qui en est la victime de vaquer à ses occupations ordinaires, familiales, sociales, ou professionnelles. Ce sera donc le rôle du service médico-social de lui fournir les moyens, les conseils, et l'assistance qui lui permettront de s'adapter à cet état passager, mais difficile et pénible.

Par *travail d'équipe*, nous entendons l'effort soutenu d'un groupe de personnes qui conjuguent leurs connaissances, leur conscience professionnelle, et leurs techniques pour la poursuite d'un but déterminé.

La réhabilitation totale d'un malade est une tâche des plus complexes—l'infirmière spécialisée en service social ne pourra, il va s'en dire, l'accomplir seule. Son rôle, d'ailleurs, n'est-il pas de seconder dans toute la mesure du possible les médecins traitants? D'autre part, sa mission est également de préparer le patient à accepter sa condition et les traitements destinés à l'améliorer. Cette mission,

Mlle Gagnon est attachée au centre anti-cancéreux de l'Hôtel-Dieu de Québec.

on le comprendra, ne peut être menée à bien que si toutes les personnes du service acceptent de mettre en commun leur science et leur dévouement dans un véritable travail d'équipe pour le plus grand bien du malade. Les activités d'une clinique anti-cancéreuse nous serviront à mieux illustrer le véritable travail d'équipe.

L'INFIRMIÈRE ASSISTANTE SOCIALE

Le rôle de l'infirmière dans un service médico-social s'accomplit en deux étapes: (a) le premier contact; (b) le travail médico-social proprement dit.

PREMIER CONTACT

Dans une clinique anti-cancéreuse, l'infirmière assistante sociale doit servir d'intermédiaire entre le médecin traitant et le patient. Son action s'exerce de façon toute particulière au bénéfice du malade. Dès la première entrevue elle devra s'enquérir de son histoire médicale. Elle s'intéressera ensuite à son histoire sociale, à ses problèmes familiaux, financiers, psychologiques, puisque l'ensemble de ces problèmes est inséparable de l'état pathologique. On a signalé, et avec raison, l'influence du moral sur le physique. On comprendra, dès lors, quels services inappréciables peut rendre une infirmière spécialisée en service social. Ses connaissances psychologiques et ses techniques de travail social lui permettront de mieux disposer le patient à accepter les services du médecin et à en tirer le maximum de profit.

L'histoire médicale et sociale du malade étant ainsi préparée, il appartient à l'infirmière d'en faire part au médecin qui le traite. Ces renseignements préliminaires permettront à celui-ci de se faire déjà une opinion précise sur le patient et sur l'attitude qu'il convient d'adopter à son égard. Le médecin fera alors son examen, il posera son diagnostic et recommandera le traitement le plus adéquat. Si l'hospitalisation est jugée nécessaire, l'infirmière devra appuyer cette décision, la faire accepter, en démontrant au malade que le séjour à l'hôpital favorisera des examens plus satisfaisants et des soins plus efficaces.

Dans une clinique anti-cancéreuse, la responsabilité du diagnostic et du traitement incombe à plusieurs personnes: mé-

decin, chirurgien, radiologiste, anatomo-pathologiste, gynécologiste, radio-thérapeute, auxquels seront adjoints des représentants des différents services. Lorsque chacun de ces spécialistes a vu le patient, il est de la plus haute importance qu'une conférence de cas les réunisse avec l'infirmière assistante sociale afin d'aviser à la ligne de conduite qui doit être suivie pour le traitement. Cette mise en commun des constatations individuelles dans le domaine médical, aussi bien que sur le plan social et psychologique, permettra d'assurer l'unité d'action et une collaboration plus efficace pour le plus grand bien du malade. De plus, cette étude globale des différents aspects d'un cas particulier permettra à l'infirmière assistante sociale de mieux comprendre le rôle qu'elle doit jouer et de seconder plus efficacement tous les spécialistes traitants.

TRAVAIL MÉDICO-SOCIAL PROPREMENT DIT

Après le premier contact avec le personnel de la clinique anti-cancéreuse, le patient est fixé sur son cas, à savoir s'il doit être hospitalisé où s'il peut retourner dans sa famille. Nous considérerons donc successivement l'une et l'autre alternative pour bien déterminer quel doit être le rôle de l'assistance sociale-médicale dans chacune.

PATIENT HOSPITALISÉ

L'hospitalisation étant acceptée par le patient, grâce au travail préliminaire de l'infirmière, il y a lieu de distinguer entre le patient convenablement fortuné et celui qui n'a aucune ressource. Dans le premier cas, il semble que l'hospitalisation paraîtra moins pénible, en raison des services multiples que la fortune permet de se procurer. Dans le second, l'assistante sociale-médicale aura parfois beaucoup à faire auprès de ces malades pauvres, obligés d'accepter les services hospitaliers dans une salle commune. Le séjour à l'hôpital offre cependant aux uns et aux autres qui souffrent des mêmes misères physiques et souvent morales, d'importants avantages en particulier, celui de recevoir régulièrement la visite de l'infirmière assistante sociale qui peut exercer à leur endroit un apostolat fructueux tant au point de vue social qu'au point de vue psycholo-

gique et religieux. Pour les malades hospitalisés, le rôle de l'assistante se borne à ce que nous venons de dire, puisque tout le personnel médical de l'hôpital demeure continuellement au service du patient.

Lorsque le traitement a donné des résultats qui permettent le retour dans la famille, l'infirmière doit se préoccuper d'assurer au malade un minimum de bien-être et les médicaments indispensables à son état. Elle le disposera aussi à rester en contact avec la clinique, soit par les visites qu'elle pourra lui faire, soit par les examens périodiques, soit par la correspondance.

PATIENT EXTERNE

Dans une clinique anti-cancéreuse, le patient externe est celui qui vient à l'hôpital pour des traitements définis. Nous pourrions également ranger dans cette catégorie tous ces malades qui, après un séjour à l'hôpital ou une série de traitements, demeurent sous l'observation du médecin et de l'infirmière visiteuse.

Dans ce cas le rôle de l'assistante sociale-médicale consiste à veiller à ce que le malade demeure en contact périodique avec la clinique anti-cancéreuse. Lorsqu'il s'agit de patients dont les moyens pécuniaires sont à peu près nuls, l'infirmière doit leur assurer tout ce que requiert leur état, tant au point de vue médical qu'au point de vue social et religieux.

CONCLUSIONS

Ce bref aperçu illustrera le véritable travail d'équipe dans un service médico-social et le rôle que joue l'infirmière assistante sociale; le développement personnel de chacun des membres qui contribue au travail, l'acquisition des techniques médico-sociales, l'utilisation de tous les moyens pour la poursuite et la réalisation de la même fin. Pour sa part, l'infirmière adhère totalement au travail d'équipe par son assistance au médecin, sa compréhension vis-à-vis du malade, l'interprétation de son cas — en un mot, sa collaboration parce que là, justement, elle met en oeuvre les ressources dont l'institution ou la société dispose pour permettre au

patient de traiter sa maladie convenablement.

De plus, nous trouvons les avantages d'une spécialisation comme complètement au cours de garde-malade. Sans vouloir sous-estimer la formation donnée par nos écoles d'infirmières, nous croyons de notre devoir d'encourager nos graduées à poursuivre leurs études dans une voie qui semble vraiment répondre à leurs aspirations personnelles. En effet, dans le domaine social, pour n'en mentionner qu'un, elles trouveront un champ d'activités illimitées et des possibilités d'action qui leur procureront des joies profondes et, ce qui ne gênera rien, des rémunérations propres à répondre aux exigences d'une vie vraiment professionnelle.

Manitoba

The following are recent staff changes in the Public Health Nursing Service, Manitoba Department of Health and Public Welfare:

Appointments: *A. Cymbalist* (St. Boniface Hosp.), *Audrey Haverstick*, *Lois Joyce* (Winnipeg Gen. Hosp.) to Dauphin; *I. M. Moore* (Grace Hosp.) to Fisher Branch nursing station; *J. Lazaruk* (Winnipeg Gen. Hosp.) to Neepawa; *E. Brenner* (Grace Hosp. and University of Man. public health course) to Selkirk.

Transfers: *Lillian Blair* from Flin Flon to Brandon; *E. Crookshanks* from Neepawa to Stonewall; *Eleanor Henderson* from Selkirk to Dauphin; *Ruby Jorey* from Fisher Branch nursing station to St. Boniface; *L. Rasmussen* from Dauphin to Selkirk; *Janet Smith* from Red River health unit to northern health unit, Flin Flon; *A. Stadnyk* from St. James to Transcona; *Jessie Williamson* from Dauphin to Red River health unit.

Resignations: *Anne (Ancion) Boux* from Selkirk; *S. Liffman* from Virden to take public health course at University of Man.

On February 14, *Elizabeth Russell* completed 34 years service as director of the Manitoba public health nurses. *A. K. Smith*, educational nurse for the Cancer Research Institute, has returned from Columbia University where she received her B.S.

Lyle Creelman *Writes . . .*

Average reading time — 4 min. 24 sec.

WHEN this reaches print it will have been nearly one year since I left Canada to join the Secretariat of the World Health Organization at Headquarters in Geneva. It is high time that I began to tell you a little bit about our nursing activities, about life in Switzerland, and perhaps something of nursing in other countries as we learn of it through personal visits or in reports from WHO nurses.

The Nursing Section of WHO is very new—as a matter of fact it really isn't officially a section until approved by the Assembly which meets in May. There are two of us at Headquarters—Miss Olive Baggallay, formerly secretary of the Florence Nightingale International Foundation, who is the Chief of the Section, and myself.

To date we have 18 nurses in "the field" and, as an orientation to the WHO nursing program, you might like to know briefly where they are and what they are doing. Six of them are public health nurses assigned to malaria teams in India, Pakistan, and Thailand. The nurse on the malaria team not only assists in the initial survey which must be made but, as the program develops, she concentrates on the development of a public health nursing service, particularly for the mothers and children. These nurses have had some very thrilling experiences about which I shall tell you at another time.

A public health nurse with special preparation in pediatrics is assigned to the College of Nursing in New Delhi and is helping to improve the clinical preparation in this field. She will shortly be joined by a second public health nurse who will assist in the organization of the nursing aspects of a field training area just outside New Delhi at Najafgarh. Already at Seoul in South Korea, Miss Visscher, a Dutch nurse who recently obtained her diploma in public health nursing from McGill School for Graduate Nurses, is helping to organize a

similar training area for nurses.

On the Island of Borneo, almost on the Equator, four WHO nurses arrived at the end of January. As they all went from the winter climate of Europe and England, the physical adjustment has not been an easy one. Two who are assisting in the development of the midwifery program and the pediatric service in the Kuching Hospital, Sarawak, live in a bungalow on the compound, along with their servants, a Chinese man and wife and their six children! The others of this group are at Brunei and are engaged in a more generalized type of public health nursing. Their descriptions of making home visits to the River Kampongs will also be of interest.

Two public health nurses are assigned to venereal disease teams—one in the beautiful mountain area of Simla, India, and the other to a centre in the flat fertile area of Lower Egypt. Three nurses are doing special work in tuberculosis—two in China and the third in one of the largest sanatoria in the world (2,000 beds) just outside Athens. And, finally, Miss Dallaire from Montreal is in Haiti where WHO is cooperating with UNESCO in a fundamental education project.

You will notice from the geographical distribution that there is a concentration in the South East Asia Region. This is partly because of a great need which the countries recognized and for which they made early requests for assistance and partly because many of these projects are financially supported by UNICEF.

Perhaps you are not aware that for the administration of the programs of WHO, the world is divided into six regions: the European, African, Eastern Mediterranean, South East Asia, Western Pacific, and the Americas. To date there are only three regional offices—Alexandria, New Delhi, and Washington, where the office of the PASB (Pan American Sanitary

Bureau) serves also as the regional headquarters for WHO in the Americas. Canada, of course, is a part of this latter region. We will have a Nursing Adviser at each regional office as they are organized and as we can find suitably qualified nurses who are not already committed to important positions.

The space allotted by the editor is more than full. Very soon I would like to tell you about my first field trip which included an extensive visit in Egypt and a hurried trip to Persia and Lebanon, all most fascinating countries and with more problems to solve in nursing than you have ever dreamed of in Canada.

The Nurse and the Law

CARL LEDOUX

THIS IS THE FIRST opportunity I have had to address your profession on a topic of mutual interest. Our respective callings have a great deal in common, though this may not be apparent to the casual observer. We are both in the public service. While you minister to man's health, we look after his safety.

The health of the community is largely in your hands and, in the hour of pain and sickness, it is your capable skill which brings care and solace to the unfortunate, fanning the feeble ember of life back to the full fire and vigor of health and happiness. Your profession has no greater admirers than the men of my calling. We have seen you work under the most trying conditions without regard to self. We know that the nurse will go far beyond the call of duty in helping humanity and implementing your honored pledge. Your work comes to our notice more forcefully in small communities where epidemic and disaster are met with courage and efficiency, regardless of privation and long hours of duty.

Here is where the community of purpose between us becomes more apparent. It is our duty to bring help to the sick and the maimed, while you

restore them to a state of well-being. Frequently, tragedy is averted only by the unstinted and complete co-operation of nurse and policeman. The lost trapper, with gangrene creeping through frozen feet; the child, victim of an overturned washtub of boiling water; the crew of a wrecked freight train; the broken victim of a hit-and-run accident; the entombed miners of a major pit disaster, and many others testify to the co-ordination and integrated effort of our two professions.

I trust that my remarks will be of some value to you and that they will serve to stimulate even greater co-operation between us, by an explanation of certain phases of our work in which you can be of invaluable assistance.

Perhaps it might be as well to discuss the law first. In antiquity, and we can trace law back to the days of King Hamurapi of Babylonia over two thousand years before the birth of our Lord, the wish of the ruler was the sole law of the land. He had complete power of life and death over his subjects and dictated according to his whim or fancy.

The punishments inflicted for disobedience were terrible. They involved torture and maiming, as well as the forfeiture of life for small offences. The law, therefore, depended upon the current ruler's temperament and disposition. Hence we hear through legend and history of some king being "good," while another is

Sub-Inspector Ledoux has been associated with the Criminal Investigation Branch of the British Columbia Provincial Police for a number of years and is at present in charge of the Provincial Police Training Depot.

termed "bad," according to the laws he created. The lowly individual not born to the purple had no rights at all. Under our present system, the law (at least in democratic countries) is the will of the people, expressed through their elected representatives and is enacted for the peace, happiness, and good government of the community.

Many people say we are over-governed, that we have too many laws, and that they are an impediment to our progress. Let me put it this way. If a man lived on a desert island alone, he would have no need for law. His every wish would be his own law of the moment. But let someone else come to the island to live and the picture immediately changes. These two people must have some rules to govern themselves so that each may enjoy his full rights and liberty without fear of infringement by the other. They must arrange a system of penalties for non-compliance with the rules. As the community grows, the need for rules or law becomes greater. Interests differ by reason of occupation, temperament, and habit. Therefore the greater the size of the community, the greater the number of laws that are required for its proper governance.

Again, we have inventive and industrial development to contend with. Let us take the automobile. A hundred years or so ago, there were laws governing teamsters, drivers, and wagoners. Racing horses on the highways was prohibited. The laws for the governance of traffic were few and easily complied with. Now, however, with the advent of the motor car, there has been a considerable increase in legislation to meet new problems. The law appears to have increased in proportion to the number of vehicles on the road. We have a motor vehicle act in every province in Canada. There are special laws for motor carriers. The criminal code has a number of sections respecting motor vehicles, and there are a host of ancillary statutes such as the Gasoline Tax Act and so on. Even with all this legislation, we have the unhappy spectacle of hundreds of lives being

lost in Canada every year through automobile accidents.

As the complexity of life increases, so does the necessity for additional rules or law. If you think we have too many laws, think of the dictatorships, where law governs man's every action, even to dictating what he may think. Law of this type ceases to be justice, but becomes plain bondage.

The law provides safeguards for rich and poor alike, rendering both justice and protection. Without the balance wheel of the law, the community would disintegrate, licence would be rife, and the only protection would lie in the use of force—a retrogression to the animal state.

Now, the leaders of a community are the ones who, by example and observance of the law, set the moral "tone" for their fellows. If they assist the processes of the law, then justice will prevail, but if they are indifferent justice will have received a severe set-back.

I unequivocally place nurses among the leaders of the community, both by virtue of their work and their high moral standards. Thus it behooves the nursing profession to lend every possible assistance to the cause of justice for the common good. The nurse has a very high responsibility both to patient and doctor but this responsibility does not stop with the physical condition of the patient. It also extends to his spiritual and temporal rights when they must be safeguarded by others through his incapacity. The victim of a cowardly attack has the right to demand justice. It is not sufficient to save his or her life, but the person guilty of perpetrating this crime must be brought to trial and punished for violating the rights of his victim. The nurse can greatly aid this process and, unless she fully co-operates, she will only have partly fulfilled her pledge to her professional standards and to the community which holds her in such high esteem.

Let us discuss the ways and means in which nurses may help. Frequently, the victim of a hit-and-run automobile accident or of a homicidal attack

is brought to the hospital directly from the scene of the crime. It becomes the nurse's duty to prepare the victim for medical attention. This is her first contact with the patient and naturally her principal thought is for the preservation of life. However, there are a number of factors in which we are vitally interested from the moment the patient enters the hospital. Take the clothing, for example. A patient's clothing is often in very bad condition, fouled with blood and mud, torn and useless. We have many instances of clothes in such condition being thrown away or burned in the furnace to get rid of them.

From our point of view this is very poor policy and may result in the escape of the guilty person from the just consequences of his act. *Clothing, regardless of its condition, should be preserved until the investigation is completed.* In a hit-and-run case, there is a possibility that a button ripped from a coat may be found in the radiator grill of the offending vehicle, or perhaps a few shreds of material may be wedged in the bumper, or there may be a few broken flecks of paint embedded in the victim's clothing, forced into the fabric at the time of impact, and so on. The garments would be, therefore, a prime necessity to the prosecution.

(To be continued next month)

Expert Committee on Nursing



Nurses from a variety of countries met under WHO auspices to recommend adequate training programs for nurses and measures to improve their economic and social status.

Around the table (left to right) may be seen: ELIZABETH BRACKETT, Nursing Adviser, Rockefeller Foundation, Paris; Mlle M. L. DAVID, Assistant Director, School of Nursing, Ecole Professionnelle d'Assistance aux Malades, France; the interpreter; Miss T. K. ADRAVALA, Chief Nursing Superintendent, Directorate General of Health Services, India; YVONNE HENTSCH, Director, Nursing and Social Service Bureau, League of Red Cross

Societies, Geneva; LYLE CREELMAN, Nursing Section, WHO; VENNY SNELLMAN (vice-chairman), Inspector of Nursing Education, Finland; MARY I. LAMBIE (chairman), Ex-Director, Division of Nursing, New Zealand; OLIVE BAGGALLAY, Nursing Section, WHO; DR. MILLER; MISS MURRAY, secretary (in corner); Miss F. N. UDELL, Chief Nursing Officer, British Colonial Office; DAISY BRIDGES, Executive Secretary, International Council of Nurses; MISS G. PEAKE, Director, University School of Nursing, Chile; MRS. A. S. W. CHAGAS, Chief, Nursing Section, Pan American Sanitary Bureau, Washington.

Trends in Nursing

Average reading time — 6 min. 24 sec.

General Interest Sessions

THE PLANNING COMMITTEE met on January 30, 1950, discussed plans and agreed upon the following exhibits and demonstrations to be presented at the C.N.A. biennial meeting in June:

(1) Neurological nursing; (2) Body mechanics in nursing; (3) Demonstration of special equipment for industrial nursing; (4) New type of V.O.N. bag; (5) Central supply room; (6) Premature nursery equipment; (7) Special recovery room—chest surgery; (8) Cardiac surgery; preoperative and post-operative care of "The Tetralogy of Fallot"; (9) Educational program as carried out in the Division of Tuberculosis Control; (10) Intravenous team; (11) *a.* Audiometer testing, *b.* Telebinocular, *c.* Wood's Light in diagnosis of ringworm; (12) Budgetting in nutrition; (13) Use of Cantor tube in intestinal obstruction; (14) "The Team" caring for the patient, in and out of hospital (emphasis on the social worker); (15) Equipment used in homes for treatment of arthritis; (16) *a.* Treatment of anterior poliomyelitis, *b.* Burn therapy; (17) Diagnosis and treatment of cancer; (18) Attractive favors, place cards, etc.; (19) The oscillating bed; (20) The showing of films; (21) The artificial kidney; (22) Rehabilitation; (23) Pediatric surgical nursing; (24) Pediatric medical nursing; (25) The Foster bed; (26) The recovery room; (27) Psychiatric nursing—A series of photographs will be taken for the purpose of illustrating psychiatric nursing from admission to discharge. Equipment will be set up for electric shock and electronarcosis and nurses will be selected to demonstrate and explain.

The Needs of the Patient

The Ward and Departmental Sisters' Section reported the setting up of a sub-committee to consider hospital nursing duties in terms of patients' needs. The Section felt that,

although the job analysis being undertaken by the Nuffield Provincial Hospitals Trust into the task of a nurse would yield much interesting information on what the nurse actually does in hospital, something complementary was needed, something which would give a picture of *optimum* nursing conditions—an analysis of the ideal care different types of patients should have from the time of admission to discharge and rehabilitation. Such an analysis it is felt would be valuable because it is complementary to the purely factual survey on which the Trust is engaged.—*excerpt from* "What The Royal College of Nursing is Doing" (Feb. 16, 1950)

The Experts Report

In this press release the World Health Organization reports on recommendations made by an Expert Committee of WHO which met in Geneva in February, 1950.

In the committee's opinion, efforts to improve the acute shortage of health personnel in the nursing field require three simultaneous and related approaches:

(a) The securing of candidates for training of all types; (b) the promotion of the most effective use of various categories of nursing personnel; (c) provision of expanded educational facilities.

The committee recommends: (1) That studies be made on the national and international levels of factors preventing recruitment (competition of more attractive professions, customs, and traditions, lack of sufficient type of training). (2) That, as the above factors are directly related to the social and economic status of women and to psychological attitudes of related health personnel and other professional groups, these studies be conducted by a staff, including psychologists and sociologists. (3) *a.* That a joint WHO/ILO pilot study be undertaken

on working conditions of nursing personnel, including hours, salaries, health conditions, and other personnel policies; *b.* That this study include the qualifications of nursing personnel, adequacy of supervision, standards of service, and problems of recruitment; *c.* That the non-governmental International Council of Nurses be requested to assist with this pilot project. (4) That modern health work, based on the new approaches toward physical, social, and mental environment, requires a basic change in education procedures for nurses: (a) in regions with highly organized programs of nurse training (reorientation to give trainee insight into psychological problems of nursing); (b) in regions in which nursing education is in early stages of development.

The committee formulated a series of recommendations setting minimum requirements at all levels for nursing personnel. WHO's role, the committee stated, should be:

(1) To provide governments with information on various aspects of nursing, including the available training programs throughout the world. (2) To foster educational opportunities through fellowships, international seminars on nursing problems, and promote a wide distribution of nursing literature everywhere.

The Expert Committee also asked WHO to undertake fundamental research using anthropological and sociological methods to determine the real health need of people in societies at various stages of development.—*WHO Press Release No. 36 (Mar.2.50)*

I.L.O. Interested

The International Labor Organization representative to the second World Health Assembly made this statement:

That I.L.O. has particular interest in

two aspects of world health: first, in the health of the industrial worker and the development of programs in industrial hygiene and, second, *in the working conditions under which personnel in health programs are employed.* The I.L.O. is especially concerned about the working conditions of nurses throughout the world and it expects to give attention to their improvement wherever possible.—*American Journal of Nursing* (Dec. 1949, p. 766)

Revised Booklet

The Canadian Nurses' Association is very proud to present to you the revised edition of "What You Want to Know about Nursing." You have been waiting for it for a long time but we are sure you will agree that it was worth waiting for. We are pleased to tell you that this lovely booklet is the work of the Information Services Division, Department of National Health and Welfare, by authority of the Minister, the Hon. Paul Martin. You will be proud to place this book in school libraries and in the hands of high school students. The format is attractive, the print good, the illustrations of real people in actual situations are excellent, and the subject matter authoritative. The message from Dr. G. D. W. Cameron, Deputy Minister of National Health, lends the book prestige and should appeal to the idealistic young girl. Copies have been mailed from the Department of National Health and Welfare to all provincial nurses' associations. Additional copies may be secured, free of charge, through your Provincial Department of Health. We hope you will like the way the story has been presented and will find the book a help to you in interpreting nursing to the potential student.

The Minister of Immigration in Australia is reported to have asked the newspapers there to stop using the term "D.P." in relation to the new-comers. "The newspapers applauded the Minister's plea and have co-

operated generously in avoiding use of the term."

While no such governmental request has been made in Canada, we would do well to follow Australia's example.

Orientation et Tendances en Nursing

Y A-T-IL SUFFISAMMENT D'INFIRMIÈRES AU CANADA POUR RÉPONDRE AUX BESOINS DE LA POPULATION?

Les statistiques que nous avons sur le nombre d'infirmières, pouvant répondre aux demandes toujours croissantes de la population, datent de 1948. Malheureusement, ces chiffres sont inadéquats, étant basés sur le retour d'un questionnaire auquel 65 pour cent ont répondu.

Le nombre d'infirmières requises pour remplir les postes disponibles en 1948 était évalué à 8,000. Bien que la demande d'infirmières semble excéder de beaucoup l'offre, combien de gens sont au courant de l'augmentation proportionnelle du nombre d'infirmières et de la population?

Durant les 20 dernières années, le nombre d'infirmières enregistrées au Canada, en service actif, s'est augmenté de 180 pour cent et actuellement on compte 41,159 infirmières. Le nombre d'infirmières graduées a marché de pair avec l'accroissement de la population.

En 1931, il y avait 1 infirmière graduée pour 690 de population; en 1941, 1 pour 445; en 1948, 1 pour 349.

Il y a eu des changements très marqués et significatifs dans les principales catégories de la profession, tel que démontré par le tableau suivant:

Infirmières du service privé: 1930 (6,370—60%); 1943 (6,327—29%); 1948 (2,886—15%). Infirmières dans les hôpitaux: 1930 (2,639—25%); 1943 (10,705—48%); 1948 (12,846—67%). Infirmières en hygiène publique: 1930 (1,521—15%); 1943 (3,241—15%); 1948 (3,017—16%).

Vous remarquerez que le service privé, comptant 60 pour cent du total des infirmières, est tombé à 29 pour cent, bien que le nombre d'infirmières engagées dans ce service soit à peu près le même en 1930 et en 1943.

Dans les hôpitaux on note une augmentation considérable d'infirmières—elles passent de 2,639 en 1930 à 10,705 en 1943, soit de 25 à 48 pour cent du nombre total des infirmières. En hygiène publique, bien que le pourcentage soit le même, le nombre d'infirmières est augmenté de 1,521 en 1930 à 3,241 en 1943. En 1948, ces changements sont encore plus marqués, mais comme les renseignements que nous avons reçus sont

incomplets, seulement 65 pour cent des questionnaires nous sont revenus, nous ne donnerons aucun chiffre.

LE COMITÉ DU PROGRAMME, A.I.C.

Lors de la réunion de ce comité en janvier, divers projets furent étudiés et l'on adopta que les démonstrations et les exhibits suivants seraient présentés lors du congrès biennal de Vancouver: (1) Le nursing en neurologie; (2) posture en nursing; (3) démonstration de l'équipement employé en nursing industriel; (4) les nouvelles troupes des infirmières du V.O.N.; (5) service central; (6) l'équipement d'une pouponnière de prématurés; (7) salle post-opératoire — chirurgie pulmonaire; (8) chirurgie cardiaque: soins pré- et post-opératoires; (9) programme d'éducation populaire de la division de la tuberculose; (10) l'équipe de la transfusion; (11) appareils audiométriques — appareils d'optique — le diagnostic de la teigne à l'aide de la lumière de Wood; (12) budget alimentaire en nutrition; (13) emploi du tube Cantor en obstruction intestinale; (14) l'équipe travaillant au rétablissement du malade à l'hôpital et en dehors (on appuiera sur le rôle de l'auxiliaire sociale); (15) l'équipement employé à domicile pour le traitement de l'arthrite; (16) traitement de la poliomyélite antérieure — des brûlures; (17) diagnostic et traitement du cancer; (18) faveurs et cartes d'invités, etc.; (19) nouveau genre de lits mobiles; (20) présentation de pellicules cinématographiques; (21) rein artificiel; (22) réhabilitation; (23) le nursing en pédiatrie chirurgicale; (24) le nursing en pédiatrie médicale; (25) le lit Foster; (26) la salle post-opératoire; (27) le nursing en psychiatrie — une série de photographies sera utilisée pour illustrer les soins donnés aux malades depuis l'admission au départ. Des infirmières feront des démonstrations.

LES BESOINS DU MALADE

Les infirmières des hôpitaux d'Angleterre ont formé un sous-comité chargé d'étudier le travail des infirmières en rapport des besoins du malade. Bien qu'une étude ait été faite dans ce sens par le "Nuffield Provincial Hospitals Trust," le sous-comité est d'avis qu'une étude supplémentaire doit être faite, afin de donner une idée optimale des soins requis par diverses catégories de

malades de leur admission à leur départ de l'hôpital et durant leur convalescence.

Une telle analyse serait très utile comme complément de l'enquête qui se fait actuellement.—*Extrait du "What The Royal College of Nursing is Doing"* (16 fév. 1950).

LE RAPPORT DES SPÉCIALISTES

Dans un communiqué de presse de l'Organisation Mondiale de Santé, on rapporte les recommandations du comité pour remédier à la pénurie d'infirmières. Dans l'opinion du comité, les efforts doivent porter sur les trois points suivants: (a) Recruter des candidates pour tous les divers cours donnés; (b) intensifier une meilleure utilisation du personnel; (c) prendre les dispositions pour faciliter l'enseignement.

Le comité fait les recommandations suivantes:

1. Qu'une enquête nationale et internationale soit faite, afin de connaître les facteurs défavorables au recrutement (profession plus attrayante, coutumes, tradition, manque de préparation).

2. Comme les facteurs énumérés ci-dessus ont une influence directe sur le statut social et économique de la femme, sur l'attitude du personnel des services de santé et des membres des autres professions, il est recommandé que cette étude soit faite par un comité comprenant un psychologue et un sociologue.

3. Qu'une étude conjointe de O.M.S. et d'un autre organisme soit faite sur les conditions de travail, heures et salaires du personnel infirmier, conditions de santé, etc.; que l'on étudie les qualifications du personnel, si la surveillance est suffisante, les standards du service et les problèmes du recrutement. Que le Conseil International des Infirmières, lequel n'a aucune attache politique, soit chargé d'une enquête témoin (pilot study).

La médecine moderne, tenant compte de l'influence du physique, du social, et du mental, exige un changement fondamental de l'enseignement aux infirmières: (a) Dans les pays où les études d'infirmière sont bien organisées, une nouvelle orientation s'impose, afin que les étudiantes reconnaissent et comprennent les problèmes psychologiques; (b) dans les pays où l'établissement d'écoles d'infirmières est chose relativement nouvelle, les études devraient être dirigées dans le même sens.

Une série de recommandations, concernant les qualifications requises du personnel in-

firmier, a été présentée. Le rôle de ce comité de l'O.M.S. doit être: (1) De procurer aux gouvernements des renseignements sur toutes les questions concernant le nursing, comprenant les programmes d'étude de par le monde; (2) de favoriser l'éducation par des séminars internationaux sur les problèmes du nursing et favoriser partout la distribution de brochures sur le nursing.

Le comité des spécialistes recommande aussi à l'O.M.S. de faire des recherches afin de déterminer, à l'aide de méthodes anthropologiques et sociales, les besoins réels des populations.

L'ORGANISATION INTERNATIONALE DU TRAVAIL

Cette organisation fit la déclaration suivante à la seconde réunion de l'O.M.S.: "Que l'O.I.T. est intéressée particulièrement dans deux aspects de la santé mondiale—en premier lieu, dans la santé des ouvriers de l'industrie et dans le développement d'un programme en hygiène industrielle; en second lieu, dans les conditions de travail du personnel employé dans les services de santé (hôpitaux, agences diverses, etc.). L'O.I.T. s'intéresse particulièrement aux conditions de travail des infirmières à travers le monde et portera son attention à l'amélioration de ces conditions.—*American Journal of Nursing* (déc. 1949, p. 766).

BROCHURE REVISÉE

L'Association des Infirmières du Canada vous présente avec fierté la brochure intitulée "What You Want to Know about Nursing" entièrement révisée. Il y a longtemps que cette brochure était attendu mais vous verrez que cela en valait la peine.

Il nous fait plaisir de vous informer que cette jolie brochure a été publiée en français et en anglais par le Ministère de la Santé Nationale, Division de l'Information.

Dans toutes les bibliothèques scolaires ce livre aura sa place, comme entre les mains des élèves des écoles supérieures, et nous l'offrirons avec fierté aux directeurs des maisons d'enseignements. Le format est commode, l'impression soignée, et les illustrations photographiques d'après nature sont vivantes. Le texte donne les exigences des diverses provinces et les qualifications requises des candidates.

Un message par le Dr. G. D. W. Cameron, Sous-Ministre de la Santé Nationale, donne du prestige à la brochure et touchera les

jeunes filles ayant de l'idéal. Le Ministère de la Santé National a déjà fait parvenir un exemplaire à chaque association provinciale

des infirmières. Ces brochures seront distribuées par le Ministère de la Santé de chaque province.



WHEN THIS NUMBER of the *Journal* reaches you, the 1950 biennial meeting for which you have been planning for months will be just around the corner and your plans will be pretty well crystallized. Although this is being written on a gloomy day in early April, there has been already a heavy registration for both Work Conferences and General Interest Sessions. If, however, at the last moment you find yourself able to go to Vancouver, do not despair because someone else may have had to cancel a reservation. Contact National Office as quickly as possible, fill in your registration forms correctly, stating your preferences, and we will do what we can to make a place for you.

If the conferences are all bulging at the seams, there are always the General Interest Sessions. In these sessions, you will find something for everyone. This part of the program promises to be provocative, interesting, and informative. The only trouble will be that we cannot all be everywhere at once.

In earlier issues, we have mentioned three Work Conferences that should make a special appeal, namely, "Staff Education," "Meeting the Total Needs of Long-Term Patients," and "Student Nurse Work Conference." We can now present to you the outlines for these conferences:

STAFF EDUCATION

Consultants: **May Palk**, educational director, Toronto Branch, V.O.N.; **Eileen Cryderman**, director of nursing service, East York-Leaside Health Unit, Toronto; **Gladys Sharpe**,

director of nursing, Toronto Western Hospital; **Helen Carpenter**, lecturer, University of Toronto School of Nursing.

Work conference purpose: To provide an opportunity for the study of certain aspects of an educational program designed to develop the optimum potentialities of each nurse and thereby result in an improved nursing service.

Overview: The development of the potentialities of each nurse through a co-operative educational process is a premise widely acknowledged. That such development results in an improved nursing service with heightened satisfaction to the participant is also accepted. In this work conference it is proposed to study and share experiences and ideas related to the foregoing assumptions. It is generally recognized that nurses employed in the various fields of nursing experience common problems. It is suggested, therefore, that registrants select an area of interest and study their problems together, thereby enriching the discussion.

Sub-topics (areas of interest):

1. THE ORIENTATION OF THE NEWLY-APPOINTED NURSE.

Is the principle of orientation sound? If so, by whom should the program be initiated? Should it precede or parallel employment? How may the success of such a program be determined?

2. THE IN-SERVICE PROGRAM FOR STAFF NURSES.

What measures might be taken by the employing agency to discover the specific needs of staff? How may the individual nurse be assisted to recognize

her needs? Should all organizations providing nursing service accept responsibility for the continued development of staff? Should the responsibility for educational opportunity be shared? How may the success of such a program be assessed?

3. SPECIFIC METHODS OF STAFF EDUCATION.

How may the methods of interview, individual conference, group conference, project, committee and research be employed in the development of educational activities?

Additional or alternate aspects of the topics may be discussed as indicated by the interests and problems of the registrants.

MEETING THE TOTAL NEEDS OF LONG-TERM PATIENTS

Consultants: **Dr. Martin Cherkasky**, Home Care executive, Montefiore Hospital, New York; **Alice Gage**, supervisor, Montreal Branch, V.O.N.; **Christine Livingston**, chief superintendent of nurses, V.O.N., Ottawa; **Pearl Morrison**, superintendent, Queen Elizabeth Hospital, Toronto; **Helen Sutherland**, provincial supervisor, T.B. Social Service, B.C. Dept. of Health & Welfare; **Mrs. Edith Pringle**, inspector of hospitals, Hospital Insurance Service, B.C. Dept. of Health & Welfare.

General objective: To provide opportunity for a study of the needs of the long-term patient and how to use to the best advantage the personnel and community facilities available to meet these needs.

Work conference purposes: (1) To discuss the meaning of the phrase "long-term or chronic illness." (2) To consider the needs of the long-term patient and ways by which these may be met. (3) To consider problem of aging in relation to chronic illnesses and disabilities which accompany old age. (4) To consider community resources available to meet these needs such as care in the home, care in hospital. (5) To consider the need for an educational program in a hospital caring for the chronically ill patient. (6) To discuss the role of the doctor, nurse, physiotherapist, occupational therapist, social worker, and practical nurse

as members of a team in meeting these needs.

Sub-topics (areas of interest):

1. NURSING CARE AND TECHNIQUES IN THE CARE OF THE CHRONICALLY ILL.

What is the function of teamwork in the care of the chronically ill patient at home? What are the needs of the chronically ill patient? How can we meet them?

2. ADMINISTRATIVE ASPECTS OF A HOME CARE PROGRAM.

What are some of the problems encountered both within and without the hospital in setting up a home care program? What factors might enter into the selection of patients for a home care program?

3. THE AFFILIATION OF STUDENT NURSES, EITHER IN AN AGENCY OFFERING HOME CARE OR IN SPECIAL HOSPITALS FOR LONG-TERM PATIENTS.

How can we present a more accurate, more comprehensive picture of illness and health to the student in hospital? How can we develop an educational program for nurses in a chronic hospital? What kind of staff education programs do we need in chronic hospitals?

4. REHABILITATION OF THE LONG-TERM PATIENT.

What is the difference between the handicapped and the chronically ill? How can we make rehabilitative services available to the long-term patient? What measures can we take to re-establish the emotionally unrehabilitate?

STUDENT NURSE WORK CONFERENCE

Consultants: **Margaret E. Kerr**, editor and business manager, *The Canadian Nurse*, Montreal; **Lenora Kelly**, acting superintendent of nurses, Vancouver Unit, B.C. Division of T.B. Control; **Isobel Black**, district supt., V.O.N., Montreal; **Sr. M. Felicitas**, director of nurses, St. Mary's Hosp., Montreal.

General objective: To provide an opportunity for nursing students to meet informally on a national level and consider the challenges of professional responsibility.

Work conference purposes: (1) To consider the student's opportunity to inter-



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pret nursing to girls of her own age. (2) To discuss the values in student government and how to organize such a body. (3) To consider the purposes of a provincial nurses' association and how the provincial association promotes professional development. (4) To consider how the Canadian Nurses' Association functions in the interests of nurses and nursing.

Sub-topics:

1. INTERPRETATION OF COMMUNITIES' NEEDS FOR NURSES TO HIGH SCHOOL GIRLS.
 - (a) The communities' needs for nurses and how to interpret nursing to high school girls.
 - (b) Drawing up manual for use in nurse recruitment.
2. PURPOSES AND RESPONSIBILITY OF A STUDENT ORGANIZATION WITHIN A SCHOOL OF NURSING.
 - (a) Purposes and responsibility of a student organization within a school of nursing.
 - (b) Study of Constitution and By-laws now in use. (Samples on hand)
 - (c) Drawing up a model Constitution and By-laws for schools of nursing having none.
3. PURPOSE AND RESPONSIBILITY OF A PROVINCIAL NURSES' ASSOCIATION.
 - (a) Purpose of Provincial Nurses' Associations.
 - (b) Why we need registration or licensing Acts. Study of Provincial Acts.
 - (c) Relationship of Student Associations to Provincial Associations.
 - (d) Relationship of Provincial Nurses' Associations to the Canadian Nurses' Association.

News Notes

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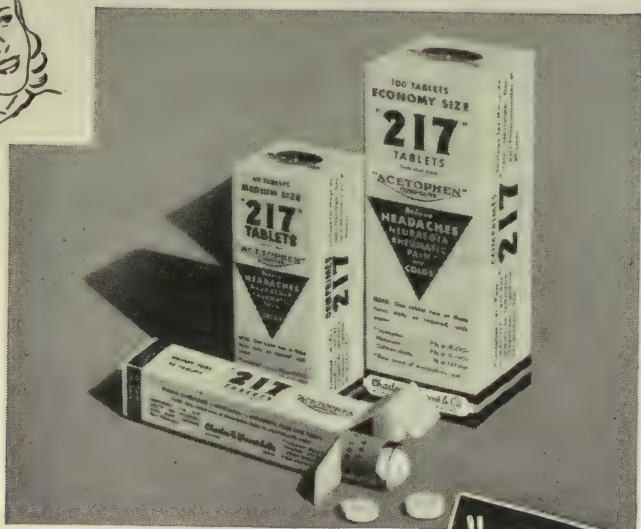
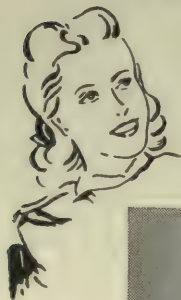
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THE CANADIAN NURSE

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DR. H. ROBINSON

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CRIPPLED CHILDREN
GRETTA M. ROSS

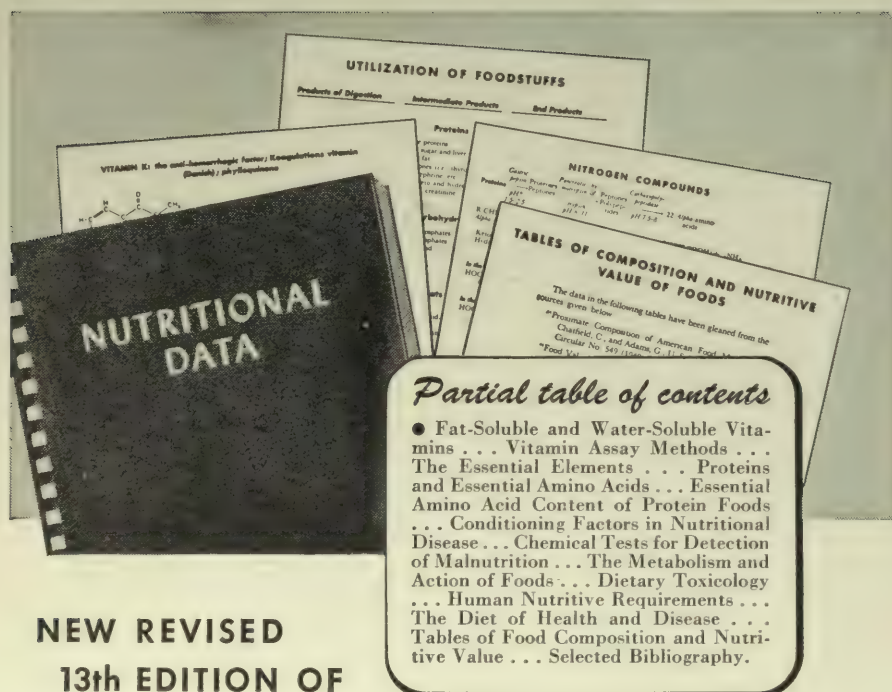


OVERNIGHT HIKE

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(See page 543)*



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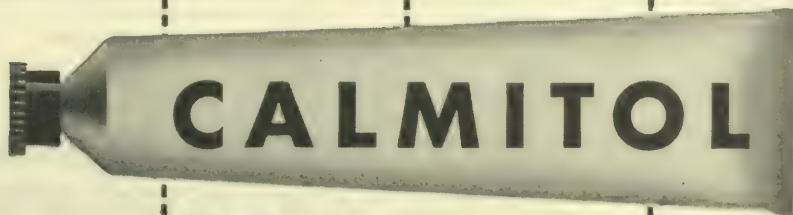
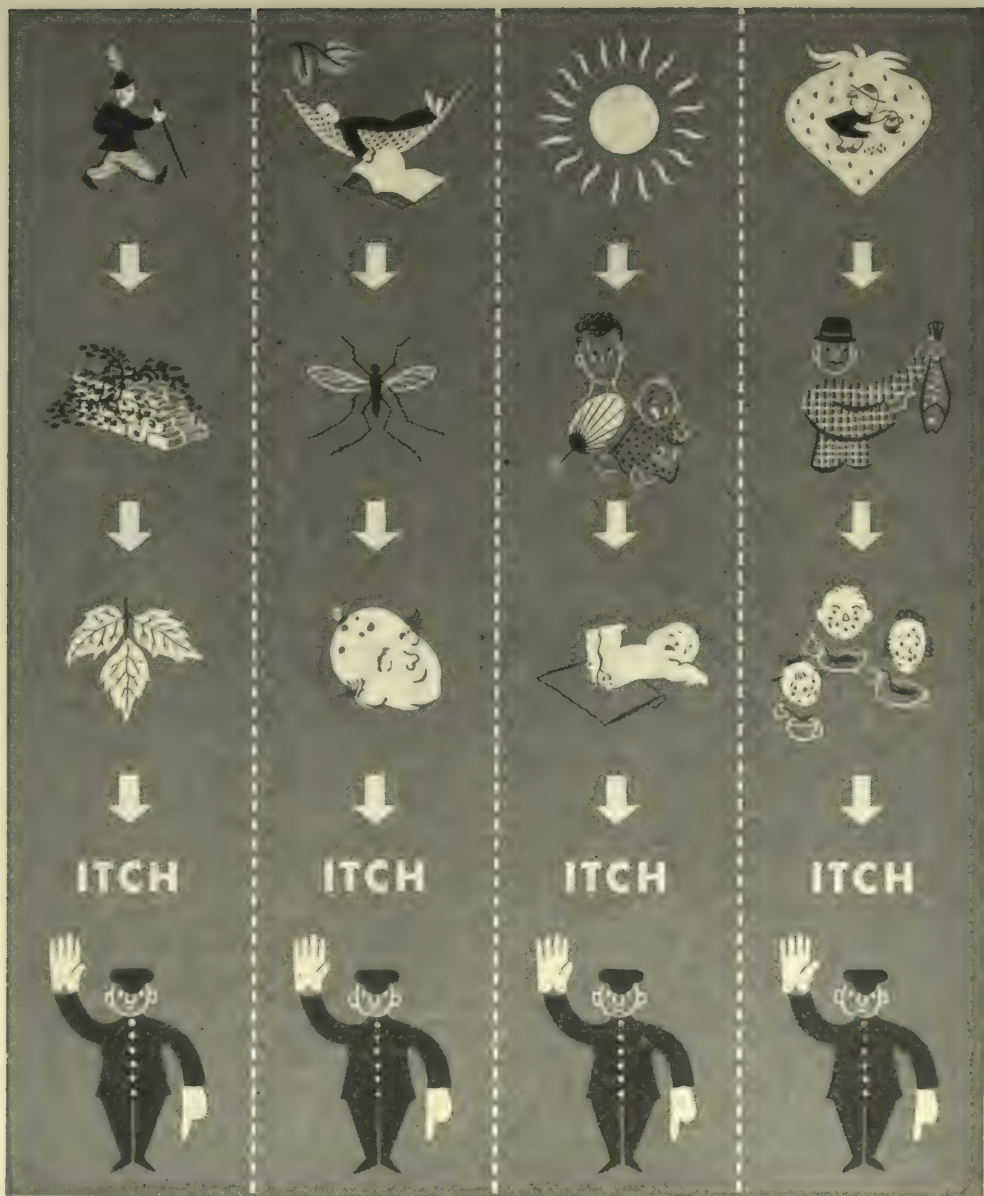
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The Canadian Nurse

VOLUME 46

NUMBER 7

JULY, 1950

NEW PRODUCTS.....	518
THE HIGHEST POSSIBLE LEVEL.....	523
CHRONIC ARTHRITIS.....	<i>H. Robinson, M.D.</i> 525
PROBLEMS IN NURSING ARTHRITICS.....	<i>E. Jermyn</i> 530
OCCUPATIONAL THERAPY FOR THE CHRONICALLY ILL.....	<i>M. E. Stocker</i> 532
DEFINITIONS OF FUNCTIONS.....	<i>Sr. M. J. Tougas</i> 535
THE NURSE AND THE LAW.....	<i>C. LeDoux</i> 538
CAMPING FOR CRIPPLED CHILDREN.....	<i>G. M. Ross</i> 543
THE BATTLE AGAINST LEPROSY.....	<i>H. Ast</i> 547
A STUDY OF CONGENITAL HEART DISEASE BY CARDIAC CATHETERIZATION <i>B. C. Brown, M.D., N. J. England, M.D., P. P. Hauch, M.D., J. A. Lewis</i>	548
LES AIDES DANS L'EQUIPE EN NURSING.....	<i>A. Lindblad and M. Struve</i> 554
AUXILIARY WORKERS IN HOSPITALS.....	<i>H. M. King</i> 558
NURSING PROFILES.....	562
LYLE CREELMAN WRITES.....	565
ANNUAL MEETING IN ALBERTA.....	<i>C. Van Dusen</i> 567
TRENDS IN NURSING.....	571
ORIENTATION ET TENDANCES EN NURSING.....	573
NUTRITIONAL ANEMIA.....	<i>Sr. C. Marie</i> 575
SYNTHETIC CURARE.....	<i>A. W. Haslett</i> 579
BOOK REVIEWS.....	581
NEWS NOTES.....	587
OFFICIAL DIRECTORY.....	600

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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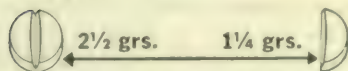


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Between Ourselves

Midsummer—and everyone is thinking of vacations. The diminished staffs in our hospitals during this time mean that those who are left on duty are extra busy. In the warm weather we all tend to put off any serious reading but don't lose track of this issue of your *Journal* as it contains many useful and interesting articles. . . .

You will enjoy reading, for instance, **Gretta M. Ross's** happy account of the summer camps conducted by the **Ontario Society for Crippled Children**. You may have to do some adjusting in your thinking regarding these crippled youngsters. Miss Ross tells about their baseball games where the lad in the wheel-chair hits the ball with base-running done by his pal. It is a marvellous opportunity for those who are less fortunate to live a near-normal life.

You will want to really study **Dr. Harold Robinson's** description of two of the commonest forms of **arthritis**. There is new promise of help and relief for the sufferers in the future. As in so many other diseases, the earlier the arthritic secures advice, the better. **E. Jermyn's** review of the nursing care of these patients supplements the medical discussion.

We felt that **Marguerite E. Stocker's** suggestions regarding **occupational therapy** fitted in with these papers very neatly, too. She has some excellent recommendations which would be very practical for every nurse to apply to her work. So often, if there is no occupational therapist on the staff, valuable opportunities are lost. If Miss Stocker's idea—of utilizing volunteer instructors from among the local residents—was used, many more forms of occupational activity could be developed quite inexpensively.

* * *

We occasionally have had nurses tell us that they prefer to read medical journals—they want the more detailed, scientific approach and explanations. For these nurses, and, indeed, for everyone, we recommend that you read the article on **heart catheterization** secured by the Committee on Private

Nursing for their Page. It is a complete reprint of the material as it appeared in *The Canadian Medical Association Journal*.

* * *

Another correspondent recently complained at length that our *Journal* did not reach her by the first of each month. We would be very happy if we could arrange for such an early publication date instead of the 10th of each month as at present. Usually, the issues are in the mails by that date. We feel we must apologize for the late delivery of your May issues. Somehow, for the first time, our printers missed the publication date by a week. Several of you wrote in wondering what had happened when you did not have your copies by the 18th or 19th. It was just one of those things! We have registered your complaints with the printer and hope it will be a long time before you have to worry again. We really try hard to have the *Journal* out on time each month.

* * *

We have had questions regarding the issue in which the various **addresses given at the convention** will be published. Our present plan is to include all of these in our *September* issue. The condensed reports of the consultants of the work conferences will be ready in time to make the pages of the *October* issue, we hope. As has been the custom since the first Mary Agnes Snively Memorial Lecture was delivered in 1946, reprints will be available after its publication in the *September* issue. This year's address was delivered by **Dr. Charlotte Whitton**.

* * *

Analysis of the factors involved in the various positions in a hospital is highly desirable to avoid both overlapping and the possibility of some important work being left undone. **Sister Tougas** has defined these various functions in terms of the practices at the Grey Nuns' Hospital in Regina. Her material will serve as a useful guide for others contemplating such a job analysis.

Contrary to general belief, the "goose-step" is not a German invention but was introduced by the British Army to enable the commanding officer to see which of his men were not entirely sober.

IN RHEUMATOID ARTHRITIS WHEN MASSIVE SALICYLATE THERAPY IS INDICATED . . .

Specify **BEREX**

In RHEUMATOID ARTHRITIS the patient must have relief from pain without danger of toxic or other untoward reactions. BEREX, the non-toxic product of choice in salicylate therapy, has been shown in authoritative tests to give definite relief from painful symptoms promptly without unpleasant after-effects of toxicity or hemorrhagic tendency even in those severe and chronic cases where massive, sustained dosage is necessary in order to maintain required salicylate blood levels.

BEREX provides in tablet form an easily-administered, balanced combination of calcium-succinate and acetylsalicylic acid. In 81% of cases of Rheumatoid Arthritis, covering an average period of three months, BEREX Therapy gave definite relief with apparent arrest of arthritic activity *without untoward reactions . . .*

*"Subsidence of fever, pain, tenderness and swelling were usually the first signs of improvement."**

*Extensive bibliography concerning BEREX in the treatment of acute and chronic Rheumatic and Arthritic disorders is available to the profession on request.

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New Products

Edited by PROFESSOR F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

NITRANITOL with PHENOBARBITAL and THEOPHYLLINE TABLETS

Manufacturer—Wm. S. Merrell Co., Toronto.

Description—Each green-scored tablet contains: Mannitol Hexanitrate 32 mg., Theophylline 100 mg., and Phenobarbitone 16 mg.

Indications—Essential hypertension, especially when associated with beginning cardiac enlargement or threatened failure, and with nervousness and apprehension. For symptomatic relief of angina pectoris, dyspnea, headache or aphasia due to vasospasm.

MERCODOL SYRUP with DECAPRYN

Manufacturer—Wm. S. Merrell Co., Toronto.

Description—Each 30 cc. contains in a palatable syrup base: Mercodione (dihydro-codeinone bitartrate) 10 mg., Nethamine (methylethylamino-phenylpropanol) hydrochloride 100 mg., sodium citrate 1.2 gm., Decapryn (Doxylamine) succinate 36 mg.

Indications—Allergic bronchitis, chronic cough of allergic origin, acute catarrhal bronchitis, tracheobronchitis, and cough due to colds.

GLYCURRANT

Manufacturer—The Allen and Hanbury's Company, Toronto.

Description—Each fluid ounce represents: Codeine Phosphate 1/3 gr., Syrup Wild Cherry 40 min., Glycerin 80 min., Black Currant Juice 165 min., Menthol 1/20 gr., Tincture of Squill 40 min., Syrup Tolu 40 min., Alcohol 5%.

Indications—Symptomatic treatment of coughs due to colds, combining respiratory sedative and stimulating expectorant effects with soothing vehicle.

EULISSIN

Manufacturer—The Allen and Hanbury's Company, Toronto.

Description—Each 2.5 cc. ampoule contains 5 mg. of Decamethonium Iodide in sterile solution.

Indications—Ensures muscular relaxation in light general anesthesia. Paralysis reaches its maximum in about 4 minutes, recovery beginning after about 10 minutes and being complete 1-2 hours.

PROGESTONE HYPOGLOSSALS

Manufacturer—G. W. Carrick Co. Ltd., Toronto.

Description—Each tablet contains 10 mg. progesterone in a special base for sublingual or buccal administration.

Indications—Conditions where progesterone may be indicated, as dysmenorrhea, functional uterine bleeding, premenstrual tension, habitual or threatened abortion.

'DISPRIN' TABLETS

Manufacturer—Reckitt & Colman Limited, England; Canadian distributor, Reckitt & Colman (Canada) Limited, Montreal.

Description—A stable tablet which contains 5 gr. of acetylsalicylic acid and dissolves in water to form a solution of calcium acetylsalicylate. 'DISPRIN' is soluble, substantially neutral and palatable.

Indications—Analgesic, antipyretic, sedative; for the relief of pain in headaches, neuralgias, toothaches, muscular aches and pains. Treatment of colds and rheumatism, etc.

VIACUTAN SOLUTION, CREAM

Manufacturer—Ward, Blenkinsop & Co., Eng.; Canadian distributor, Brent Laboratories Ltd., Toronto.

Description—1% solution and a 1% water-miscible cream containing the bactericide, silver dinaphthylmethane disulphonate, a yellow dye to show the area treated, and a wetting agent to assist spreading.

Indications—Varicose ulcers, pre-operative skin disinfection, routine antisepsis, and in obstetrics and gynecology.

PALUDRINE

Manufacturer—Imperial Chemicals (Pharmaceutical) Ltd., Eng.; Canadian distributor, Brent Laboratories Ltd., Toronto.

Description—Tablets, containing 0.1 gm. and 0.025 gm. Paludrine Hydrochloride. Ampoules, 2 cc. 5% sterile solution (0.1 gm. in each ampoule) with a pH 5.5-6.0.

Indications—Prophylaxis and treatment of malaria.

d-TUBOCURARINE CHLORIDE SOLUTION

Manufacturer—Brent Laboratories Ltd., Toronto.

Description—Sterile, isotonic solution of d-tubocurarine chloride pentahydrate 3 mg. per cc. (equal to 20 units of curare activity).

Indications—For muscular relaxation during light anesthesia, to weaken convulsions in shock therapy, primary dysmenorrhea, tetanus.

AVLON TABLETS

Manufacturer—Imperial Chemical (Pharmaceuticals) Ltd., Eng.; Canadian distributor, Brent Laboratories Ltd., Toronto.

Description—Imperial brand of methyl thiouracil. Tablets of 0.05 gm., 0.1 gm., and 0.2 gm.

Indications—Thyrotoxicosis, especially in inoperable cases or for pre-operative preparation.

CETAVLON

Manufacturer—Imperial Chemical (Pharmaceuticals) Ltd., Eng.; Canadian distributor, Brent Laboratories Ltd., Toronto.

Description—A cationic detergent, bulky powder containing about 75% cetyltrimethylammonium bromide. Available as the powder, 20% concentrated solution for dilution, 0.5% tincture, and jelly. Incompatible with anionic detergents, such as soap.

Indications—Wounds and burns, for skin sterilization, cleansing and disinfecting hospital vessels and surgical instruments. Usually employed as a 1% solution by diluting the concentrate with boiled or distilled water or by shaking up the powder with the water. Tincture for skin sterilization. Jelly for skin and for wounds, burns, etc.

RHOPAS

Manufacturer—Poulenc Laboratory Limited, Montreal.

Description—Granulated preparation (coffee flavor) containing 60% sodium paraminosalicylate, a synthetic drug which acts selectively as a bacteriostatic upon the *B. tuberculosis*.

Indications—Acute tuberculosis (supplementary to streptomycin therapy) chronic pulmonary tuberculosis (adjuvant to collapse therapy) tuberculosis empyema, laryngeal, intestinal, renal or cutaneous tuberculosis.

Administration—The usual dosage for adults is 15 to 20 gm. of granules (9 to 12 gm. of sodium P.A.S.) daily, or more according to the physician's prescription, in divided doses at regular intervals. It should be dissolved in half a glass of cold water just before taking, in order to avoid digestive upsets. The treatments may be maintained for 60 days or longer or divided into several courses of 3 to 4 weeks with a rest period of one week between courses.

SULESTREX PIPERAZINE

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Piperazine Estrone Sulphate, a synthetic product providing conjugated natural estrone in odorless, tasteless form in combination with piperazine which acts as a stabilizing buffer. Tablets of 0.75 mg. and 1.5 mg.

Indications—Conditions where estrogenic therapy is indicated, such as menopausal symptoms, senile vaginitis, kraurosis vulvae, etc.

Administration—Orally—usual dosage varies between 1.5 and 4.5 mg. daily.

PARADIONE SOLUTION

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Paramethadione, Abbott (3, 5-dimethyl-5-ethyloxazolidine-2, 4-dione). Each cc. of alcoholic solution contains 0.3 gm.

Indications—Epilepsy of the petit mal, myoclonic and akinetic type.

Administration—Orally, for older children and adults, 0.9 gm. daily in divided doses mixed with orange juice or milk increased or decreased according to response or undesired side effects. Patients should be carefully observed and complete blood and differential counts made at intervals of not less than 4 weeks. Contraindicated in patients with severe renal or hepatic disorders.

DECYL ENCOTES

Manufacturer—Barlow-Maney Laboratories; Canadian distributor, Biomedicals Ltd., Hamilton, Ont.

Description—"Encotes" are gelatin capsules, enteric coated. Each Decyl Encote contains 440 mg. undecylenic acid.

Indications—For relief and possible prevention of recurrences of psoriasis and neurodermatitis.

TRILENE

Manufacturer—Imperial Chemical (Pharmaceuticals) Ltd., Eng.; Canadian distributor, Brent Laboratories Ltd., Toronto.

Description—Trichloroethylene, specially purified, stabilized with Thymol 0.01% and colored blue.

Indications—For analgesia or anesthesia.

SODIUM GENTISATE

Manufacturer—The E. B. Shuttleworth Co. Ltd., Toronto.

Description—Each tablet contains 7 grains of sodium gentisate.

Indications—Rheumatic conditions for the relief of pain, swelling, and fever.

Administration—One or two tablets every four hours.

Death in the Water

In June, Canadian newspapers once again began to carry items telling of lives lost in drowning accidents. Many of these fatalities could have been prevented if the persons involved had followed basic safety rules. Keep your name out of the obituary column by swimming sanely. Don't swim alone or immediately after a meal or in unfamiliar waters. And don't show off in the water . . . you can't afford to gamble and lose!

Getting "In Condition"

With the onset of the vacation season the urge to "get in condition" overpowers a great many otherwise normally easy-going individuals. They plunge into a round of swimming, hiking, golf, and other violent activities without regard for their age or physical condition. More often than not the results of this sudden bout of exertion are far from good and they can be serious. Exercise in moderation until the body gets used to the idea.

For local therapy and prophylaxis of oral infections caused by penicillin-sensitive organisms.

Delightful tasting—welcomed by young or old. Potent—supplies 3,000 units penicillin in slowly dissolving hard candy base. Effectiveness lasts approximately one half hour.

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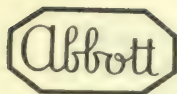
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When the Vi-Daylin bottle is opened, children come running. They smell this honey-like liquid, taste the lemon-candy flavor, and are quick to take the prescribed dose—no coaxing, no coyness here. One teaspoonful a day is the average dose for children up to twelve years old. Vi-Daylin is ideal for babies too, as it's easy to mix with formula, fruit juice or cereal. Contains practically no alcohol—less than 0.5%. For mothers there's an extra bonus—Vi-Daylin has no fishy odor, stays fresh without refrigeration. The formula shows its potency, the Abbott label assures you of its purity and stability. Vi-Daylin is obtainable in two convenient sizes: 90-cc. and 8-fluid-ounce. ABBOTT LABORATORIES, LIMITED, MONTREAL.



Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	5000 Int. units
Vitamin D	1000 Int. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Nicotinamide	10 mg.

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The

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The Highest Possible Level

Average reading time — 3 min. 12 sec.

MANY CENTURIES AGO the Roman philosopher, Marcus Aurelius Antoninus, wrote: "My city and my country, so far as I am Antoninus, is Rome, but so far as I am a man, it is the world." Thus, so long ago, he anticipated the situation in which we find ourselves today. As Canadians we are proud of our birthright, our country, our progress in so many directions. Being loyal Canadians, however, does not in any way impair our interest in and our concern about world affairs. As Canadian nurses we are particularly affected by what is being undertaken to offset the ravages of disease on a world-wide basis. Thus, we should all be aware of the purpose and activities of the body that is chiefly concerned with the vast program that is now in its third year under the World Health Organization.

Created on September 1, 1948, WHO's world-embracing objective was agreed to be "the attainment by all peoples of the highest possible level of health." With the receipt of the instruments of ratification of the WHO constitution from Nicaragua, the number of countries that are

currently members stands at 69. Of that number, unfortunately, seven have notified WHO of their withdrawal from active participation.

Though Geneva, Switzerland, is the site of the headquarters of WHO, regional offices are or will be established in many quarters of the globe.

Six fields of study and endeavor have been given top priority. In the van is *malaria* that annually strikes an estimated 300,000,000 persons, of whom about 1 per cent die. Others are so badly weakened that their productivity as agricultural workers is greatly reduced.

In this field it is easy to demonstrate that money spent on health is a sound investment. Thousands of acres of good land are depopulated or under-cultivated because of malaria. Its control is now a practical and economical possibility, thanks to DDT and other means; but an effective organization and trained personnel are essential for the success of the whole program.

An estimated 50,000,000 people fall prey to *tuberculosis* each year, with some 5,000,000 deaths. WHO has made surveys in a large number of

countries. The International Tuberculosis Campaign, providing B.C.G. vaccination for children and young adults, has already reached the phenomenal figure of 10,000,000 vaccinations in the European countries. This campaign is now being extended to the Eastern Mediterranean, North Africa, Asia, and the Americas.

WHO is seeking to reduce, through modern treatment, the high post-war rate of the *venereal diseases*. An estimated 2,000,000 deaths yearly are attributed to syphilis. Demonstration teams are already at work in conjunction with UNICEF, to promote programs of rapid penicillin treatment.

The other three top priority services include *Sanitation, Maternal and Child Health*, and *Nutrition*. Requests from member governments for technical assistance far outstrip WHO's present capacity to provide these services, not to mention the very considerable demands made in related fields. For example, a mental health expert has been requested to deal with the *narcotics* situation in the Eastern Mediterranean area. *International*

standards have now been fixed for 38 biological products, such as penicillin, streptomycin, vitamins, B.C.G., etc. Uniform names and dosages have been established for a variety of chemical drugs. The first *International Pharmacopeia*—produced by WHO—will be published this year.

Emergency aid of many kinds is also supplied by WHO. Providing for the delivery, by aircraft, of iron lungs to combat the ravages of polio; rushing medical supplies to prevent or control epidemics of typhoid, of cholera, of smallpox are but a few of the miracles this health-motivated organization performs.

To nurses bound by the four walls of a hospital, or striving to interest her small community in establishing a child health centre, or busily assisting a physician in the local immunization clinic, WHO's accomplishments seem very far away, dramatic, and somewhat unreal. Yet each nurse, as she goes about her daily tasks, is a part of the grand program of helping people everywhere to reach the "highest possible level of health." It is an inspiring thought!

Correct Procedure in a Toast

When proposing a Toast to the King, the chairman rises, brings the audience to attention, and asks them to rise and drink a toast to His Majesty. At this, the audience rises. The chairman says, "Ladies and Gentlemen, 'The King.'" Then, and only then, is the glass lifted from the table, held at eye level for a moment, one sip of liquid is taken

and the two words "The King" repeated *before* the glass is replaced on the table. No other procedure is correct for a civilian pledging the health of His Majesty. *Glasses are never clinked*. Guests must not smoke before this toast has been proposed. It is *not* correct to play or sing the National Anthem when a Toast to His Majesty is proposed.

Plural Births

The likelihood that a confinement will result in a multiple birth depends upon various factors. Age of the mother is one of them. The frequency of plural births increases progressively with advance in age of mother to a maximum at ages 35-39 and then falls off somewhat. The chances are better than 17 in 1,000 that the confinement of a woman in her late 30's will yield a plural birth. For teenage mothers, the chances are only 6 in 1,000.

—M.L.I.C. *Statistical Bulletin*

Using the Refrigerator

Once, a refrigerator was merely a place to store foods. Now, wise homemakers use it as a kitchen helper—to make meal-planning easier and, in summer, cooler. You've no idea what exciting dishes can come out of it—mousses, cheese-rings embellished with summer-fresh fruits; sherbets with novel trimmings, a regal meat-loaf decked with stewed fruit. Meals like these can be prepared hours ahead and stored till serving time. Baked dishes can then be heated before serving.

Chronic Arthritis

HAROLD ROBINSON, M.D.

Average reading time — 18 min. 24 sec.

ARTHRITIS, or rheumatism, as it is known to the lay public, is not a new condition. It was common in ancient populations. It has been found in the skeletons of neolithic cave-men and was a frequent ailment among the pre-dynastic natives of Egypt and Nubia. Spondylitis deformans, for example, was common among Egyptians as long ago as 2900 B.C. and, in one known case, as long ago as 5000 B.C. Rheumatic changes have also been found in the remains of prehistoric man, in neolithic graves in France, and in skeletons from Pompeii. Before the age of man, such animals as the extinct sabre-toothed cat of one-half million years ago, the dinosaurs and crocodiles of the lower Miocene period suffered from arthritis.

The general distinction of chronic arthritis from gout was delayed until the end of the 18th century, when an attempt was made to differentiate certain forms of rheumatism. Until recent times, the spas and watering-places, popularized by the Romans on the continent and in England, provided the only relief to sufferers of these conditions. The interest of the medical profession as a whole was stimulated by investigators who began to point out the great incidence of disability and loss of work occasioned by these conditions. At the same time it became evident that people suffering from arthritis, and not getting help from medical men, were turning to irregular practitioners, who were only too happy to lend their doubtful services. To manufacturers of patent medicine this proved a most lucrative field. As late as 1941, Dr. Hench of the Mayo Clinic reported some 550 remedies offered for the relief and cure of rheumatism.

The Empire Rheumatism Council, formed in England in 1937, exposed

a large number of "cures" for arthritis unloaded on the public. These varied from electric belts to apples. The electric belts presumably sent uninterrupted electrical impulses through the body and ostensibly one's rheumatism vanished. Actually, they were coated with an irritating chemical substance. The apples were from a special orchard and were of great efficacy in the treatment of these conditions. They could be procured at a price. These are only two samples picked at random from hundreds of like "cures."

The air of confusion about rheumatic diseases began to clear somewhat about 25 or 30 years ago. Rheumatic associations have since been set up in the larger countries—England, the United States, and the Continent and, more recently, in Canada. The whole field was re-evaluated in the light of modern knowledge and new, more adequate classifications were made. An International League against rheumatic disease has also been set up and delegates from all countries attend conventions and exchange knowledge.

The magnitude of the problem in Canada is evident when one reads the results of a survey of arthritics carried out by the Dominion Bureau of Statistics in 1947. This revealed that some 652,000 people in Canada were suffering from some form of rheumatic disease. Further, this accounted for 22.6 per cent of total time lost from work as a result of illness during the month the survey covered. The loss to our national income in one year is a substantial sum. To illustrate that arthritis is not merely a disease of the aged, consider the following figures. The onset of arthritis in 74 per cent of cases was under the age of 54. In 34 per cent the onset was under the age of 34. We have known for some time that the number of arthritic sufferers is greater than the

Dr. Robinson practises in Banff, Alta.

number of people suffering from heart disease, cancer, tuberculosis, and diabetes combined.

Before discussing any specific conditions, I would like to give you a simple classification of rheumatic disease to indicate what is included in the field:

1. *Acute rheumatism* (rheumatic fever).

2. *Gout*—acute and chronic.

3. *Non-articular rheumatism*—affects soft tissues and not joints. Includes such familiar conditions as lumbago, bursitis, panniculitis, sciatica, and pleurodynia.

4. *Chronic arthritis*:

(a) Rheumatoid type (synonym: atrophic)

i. Unknown etiology—includes classical rheumatoid arthritis and also Still's disease in children.

ii. Known etiology—includes all forms of infective arthritis, e.g., gonococcal, dysenteric, etc.

(b) Osteoarthritic type (synonym: hypertrophic and degenerative)

i. Unknown etiology—includes senile variety, e.g., *malum coxae senilis*.

ii. Known etiology—includes trauma. May be secondary to other joint disease. Central nervous system disease—arthropathy.

It is with osteo and rheumatoid arthritis that I wish to deal in this article. They are by far the most important groups of rheumatic disease from the point of incidence.

OSTEOARTHRITIS

This is a chronic joint affection thought to be due primarily to a degeneration of articular cartilage. It affects more men than women. The disease is not a constitutional one but a local condition which affects one or more joints. Though it occurs more frequently in the older age group, it is surprising how often it turns up in a robust male in his forties. It is present, more or less, in the great majority of older people though often symptomless. The main complaints are: pain and stiffness, often worse with changes in weather, in the

back, knees, hips, end joints of the fingers, etc.

Osteoarthritis, in the main weight-bearing joints as the hip, for example, often leads to some shortening of the affected limb and the patient may develop a limp as the result of this shortening and local pain. X-ray of the affected joint shows a loss of joint space, normally maintained by cartilage, together with varying degrees of overgrowth of bone about the joint, as though nature were attempting to buttress up this unstable region. Pathologically, the cartilage is worn through over the weight-bearing areas. Over a period of time the opposing bone ends become polished until they are like burnished ivory. In certain joints, as the hip, a contraction of ligaments and joint capsule, together with thickening, takes place which limits movement at the joint. It is in these contracted ligaments and capsule that a great deal of the pain sensation occurs.

The cause of this type of arthritis in the old age group would appear to be simply wearing out of the cartilage. This cartilage, elastic and resilient in young people, becomes less elastic and fibrillated in appearance in older age. With the frequent trauma of weight-bearing, the cartilage gradually wears through. In osteoarthritis in the younger people frequently the cause is more definite. Men working with power drills may develop this in their elbows—a result of frequent micro-trauma. Tailors may develop osteoarthritis at the end joints of the fingers. Injuries, such as fractures involving any joint, may cause the development of a secondary osteoarthritis.

Conservative methods of treatment can give considerable relief to this type of patient. Heat of all forms helps relieve pain. Warm baths, hot water bottles, heat lamps, and diathermy are all of use. In the case of joints with contracted periarticular structures, as in the hip, manipulation under anesthesia often increases the movement and relieves pain by stretching these painful contractures. The use of a traction pull of about

15-20 lb. for several hours daily, in the case of the hip joint, accomplishes the same over a longer time. Work in the deep pool bath enables these patients to do movements and walk in a manner impossible on land. Muscle re-education is also of prime importance in stabilizing the joint and in building up muscles wasted by disuse. X-ray therapy will occasionally relieve severe pain. Local procaine injections into painful peri-articular structures also have their place. By such measures as these a good deal can be done to make the lot of the osteoarthritic a good deal more comfortable.

RHEUMATOID ARTHRITIS

This is the number one crippler of the chronic arthritis group. It is the disease which, unless checked in its course, may result in complete invalidism. It is a constitutional disease—that is, not just a disease of joints but of the body as a whole. Rheumatoid arthritis is a progressive disease characterized by a polyarthritis, inflammation and wasting of muscles, loss of weight, anemia, fever in the early stages, and an increase in the sedimentation rate. Classically a disease of young women in the child-bearing period, today we know it affects all ages and both sexes. Women, however, predominate.

The disease begins insidiously with stiffness and soreness in the fingers in the morning. There is often an associated feeling of lassitude with some diminution of appetite. Swelling usually occurs in the small joints of the fingers, usually at the metacarpophalangeal and proximal inner phalangeal joints. As the disease continues, more joints are involved in a centripetal fashion—the wrists, elbows, shoulders, feet, knees, and hips. Later the joints of the jaws may be involved, resulting in difficulty in opening the mouth and eating. Progression is not usually steady. There are periods of improved health, followed almost invariably by repeated attacks. This insidious progression of damage continues until one day the patient finds himself a cripple. Along the way, the painful joints have

caused the muscles to go into spasm and wrists are drawn into a position of flexion, the elbows have become stiff in partial flexion, and the knees may have become bent. The fingers may have assumed a position of ulnar deviation. These joints may become stiff in any position, due to adhesion formation in the inflamed joint. Eventually these fixed joints may become healed by bone formation in these bad positions, to make correction almost impossible. We may be left then with a patient unable to walk, shave, do the hair, or feed himself—malnourished and suffering considerable pain.

Pathologically, the affected joint shows progressive destruction of cartilage from within the joint and from within the bones themselves. Granulation tissue formation destroys and takes the place of the cartilage. There are multiple areas of chronic inflammation in all the muscles of the body with wasting of the muscles. The blood shows a microcytic anemia of varying degrees. The blood sedimentation rate varies from the neighborhood of normal to 100 or 110 points of fall. This is often roughly proportional to the activity of the arthritic process. Studies show a deficiency of most of the vitamins.

The actual cause of the disease itself is unknown. However, we know a good deal about the factors which may cause a recurrence or exacerbation of the disease. Infection of one form or another may start the progression of events which lead to rheumatoid arthritis. The disease continues to progress long after the initial infection is gone, probably as a result of an acquired sensitivity. It may be also that only people with a certain constitution will develop arthritis. The people affected generally are hard workers, who have spared themselves little time for relaxation. Frequently there is an emotional problem of some sort—often these people are worriers.

Treatment of rheumatoid arthritis today has thrown into the discard a multitude of remedies which would fill this page. The student of this condition, should he believe all he

reads, would be a confused man indeed. The great William Osler, at the turn of the century, is quoted as saying, "When I see a case of rheumatoid arthritis come in the office door, I feel like jumping out of the window." Treatments have included: bee stings, cobra venom, injections of colloidal sulphur, non-specific protein therapy, colonic irrigations, vaccines of all kinds, splenectomy, spinal pumping, the use of pregnant women's blood, artificial jaundice, an infinite variety of diets and various forms of physical treatment, including x-ray. Only a few of these are in common use in clinics now.

Therapy offers a great deal of hope today to cases of rheumatoid arthritis. The earlier the treatment is given, the better the chances of recovery. I will mention only the practical approach to treatment and will not comment on treatments in the experimental stages.

If treated early and efficiently, about 25 per cent of cases are restored to normal health and regain full function of joints. Of the remainder, 65 per cent will show functional improvement from mild to good. The residue, about 10 per cent, continue to progress despite adequate treatment. The prognosis is, then, a good deal better than most people realize. Besides this, the great majority of cases can be prevented from developing a major deformity.

Authorities today feel that cases of rheumatoid arthritis should be treated along sanatorium lines. Removal from the home environment and the everyday worries is important. In the years to come, all early cases of this disease may be treated in sanatoria, as tuberculosis is today.

Treatment aims at correction of the constitutional factors, prevention of deformity and correction of existing deformity, together with education of the patient with regard to the nature of her disease and a way of life she should follow. In the early acute stages, the patient is put to rest. Weight-bearing on inflamed joints is eliminated. This prevents further damage to joint cartilages

and allows inflammation, pain, and muscle spasm to subside. During the phase of inflammation of joints, which may be present for weeks, all joints are given daily movements by a physiotherapist to prevent adhesion formation. From the beginning muscle re-education, to develop wasted quadriceps, intrinsic muscles of the hand, etc., is instituted. This prevents further wasting and allows muscle rebuilding as the disease subsides.

Inflamed joints are put to rest, whether they be in a position of flexion or not, in light, well-fitting, resting plasters. These may be used for the knees, hands, wrists, elbows, hips, and so on. In such a plaster, pain is relieved a great deal and inflammation settles down. Thus, the spasm of muscles is almost immediately relieved and flexion deformities do not occur. When there is already a flexion deformity, the relief of the spasm allows the knee, for example, to correct gradually to improved positions. The casts are purposely light in weight to allow patients to move their limbs despite the encumbrance. The casts are generally bivalved in about 48 hours to allow daily movements by physiotherapist and muscle education. They are worn until inflammation is gone.

Fixed flexion deformities may be corrected by manipulation after the disease subsides. The constitutional measures are an attempt to correct some deficiencies present. First, however, foci of infection are removed, not because this will cure arthritis but because the presence of a focus lowers general body resistance. Vitamins are added to an already adequate diet. Ferrous salts are given to help correct the anemia almost invariably present. Transfusions may be given to stimulate new blood formation and improve resistance.

There is no specific drug available to us which will cure rheumatoid arthritis. However, the use of gold salt therapy comes as close to a specific drug as any we have. After some years of controversy, it would seem that, until a magic elixir is found, gold is here to stay. It provides our most

effective means of bringing about a remission. It has been stated, that with gold one can do in six months as much as would be accomplished in six years without it. The great majority of men working in this field feel that the use of gold has been a great step forward. We do not know how it works—its use is empirical. A course of treatment of 1-3 grams is given in weekly divided doses of 50-100 milligrams. In certain cases, a maintenance dose is continued at three-week intervals for some time. All active cases are started on gold on admission, unless some special condition present precludes its use. It is given under close supervision for it is not a non-toxic drug. With proper care, serious reactions are uncommon.

Hot baths or deep pool bath therapy can be given as the activity of the disease subsides. These are used for several reasons. First, in hot springs we have the cheapest form of heat available and this is a great help in relieving pain. Secondly, this therapy is of help in teaching those people who have not walked for months or years to walk again. The extra buoyancy of mineral waters is of some help in this regard, as it allows easier movement. Gradually, these people are graduated to walk again on land.

Under this regime, the patient with early rheumatoid arthritis should count on at least three months' supervised treatment. Later cases require longer periods of time. During the period of hospitalization, lectures are given to educate patients as to the nature of their disease and after-care. Simple methods of applying home remedies, such as heat, are demonstrated. The patients are warned of those factors that may cause recurrence. Over-fatigue, infections of the nose and throat, insufficient rest, and exposure to cold and damp are all factors to be avoided. After the acute phase has subsided, patients are allowed increased liberties.

The nursing staff plays a large part

in determining the comfort and morale of these long-term patients. The nurse must know with what she is dealing and remain cheerful and helpful in the face of a physically ill and often emotionally disturbed patient. Cheerful and bright surroundings make a great deal of difference in eventual recovery. In Banff, for those patients that are up and about, there are frequent movies shown in the hospital and occasional bingo games. Most community entertainment makes a one-night stand at the hospital. All of these things make a break in the long stay. Other countries are well ahead of us in Canada in treatment and care of arthritics. Sweden has 3,000 beds set aside for treatment along these lines. England has a country-wide scheme for case-finding and treatment.

In Canada, there is a nation-wide movement to start a program of treatment and research. The Canadian Arthritis and Rheumatism Society has been formed with the help of the Canadian Rheumatism Association. This society is set up with both lay and medical directors to organize training and education, and support research and treatment centres for our 650,000 arthritics. Alberta is at present leading the way in Canada by studying legislation to provide free hospitalization and treatment for arthritis victims under the age of 20.

We hear arguments today that more should be known of the cause of rheumatoid arthritis before money is spent on treatment centres. It is true that a great deal of research is needed. However, we should not deny those suffering from the disease today the relief that can be given by adequate medical and orthopedic management. The treatment of tuberculosis has changed little in the years since the discovery of the causative agent because these patients are being treated by sound medical and physiological methods. Treatment now can save thousands from crippledom.

Your heart weighs less than a pound, yet it pumps hard enough to lift a ton seven storeys high every 24 hours.

Problems in Nursing Arthritics

E. JERMYN

Average reading time — 4 min. 48 sec.

MOST NURSES who have had the care of arthritic cases find that the endless patience required of them is the most difficult aspect of this branch of nursing. At one time I thought of nursing in an arthritic hospital as a tedious round of lifting heavy people, feeding helpless ones, and generally dealing with irritable chronic patients. Now, after experience both as nurse and patient in a hospital with a daily average of 60 arthritic cases, I know the picture is not nearly as grim as that. Instead, the cheerful attitude of both patients and staff helps to make the atmosphere the happiest that I have ever known in a hospital. The majority of patients are able to be up and about and require the lightest of nursing care, so that one has sufficient time, without being rushed, to devote to those who need a great deal of care.

Arthritic cases vary from those who have come early for treatment, and may have only one or two joints involved, to those who have received no treatment until they are helpless cripples with deformed and ankylosed joints. In age they may run from 5 to 75, but the majority are in the young adult group and more women than men are affected. This refers particularly to rheumatoid arthritis, the type that produces the greatest crippling and deformity and is also the most painful.

The treatment of rheumatoid arthritis which has produced the best results so far consists of injections of gold salts, rest, extra vitamins and iron where indicated, relief of pain by aspirin compounds, and physical therapy.

Gold injections are usually given weekly and toleration of gold must

be checked by weekly urinalysis and bi-weekly white blood count. Progress is shown by checking the sedimentation rate and hemoglobin every three weeks.

Physical therapy consists of daily manipulation by a trained masseur to loosen stiffened joints and to prevent new deformities. Daily mineral baths, in pool or tub, provide an opportunity for heat treatment and underwater exercises. The buoyancy of mineral water is an aid to exercising and gives support to those who are learning to walk again. Supervised group exercises, paraffin baths, etc., are given where indicated. Occupational therapy plays an important role in treatment, not only from the point of view of promoting muscle and joint movement, but also as a stimulus to interest in a hobby or trade and to maintaining good morale. This is supplemented by recreational therapy in the form of weekly motion pictures, bingo parties, sing-songs, selected games, and so on.

Resting casts are made for swollen or deformed joints, usually knees, hands, or elbows, and these are applied with crepe bandages for as long as possible each day. They are made with the joint in the most normal position possible. As a greater degree of flexion of the joint is obtained, the casts are remade. In some cases casts cause a great deal of discomfort at first. In time they become more bearable and later afford comfort to painful joints.

Diet should be generally well-balanced, high calorie, average protein, high vitamin content. These patients are usually admitted in a more or less run-down condition. The only restrictions are spices, condiments, concentrated sweets, fried foods, and pastry. Patients who are obese are put on a reducing diet.

Nursing bed-ridden arthritics calls for an exceptional amount of patience

Miss Jermyn won first prize given by the Arthritis Club of Banff, Alta., for the best essay on "Nursing in Arthritis." She is on the staff of the Mineral Springs Hospital, Banff.

and gentleness in handling. Because of the extremely painful condition of the patient's joints any quick or jerky movement is distressing, so morning and evening care is a slow and tedious job. A knee a fraction of an inch to one side or the other, or a pillow not quite right, makes all the difference between comfort and misery. Moving a limb too suddenly or a sudden jar is enough to cause needless additional agony.

Bed-clothes should be warm but light in weight. It is hard to realize, without experience, the misery and exasperation of trying to adjust blankets around one's neck with hands that are unable to grasp anything heavier than a handkerchief. Light bedding also facilitates changing position at night. Trying to turn even a few degrees is a slow and difficult procedure, especially for those whose joints and muscles are acutely inflamed. This produces a tendency to lie very still all night long with resultant stiffness in the morning.

As with all chronic bed-patients, special care must be given to the back and all pressure points. Be careful not to leave the patient on a bed-pan too long, as there is pain associated with this position.

With those who are able to be up and about the nursing care is much simpler and little actual attention is needed apart from making beds and giving medications. Women may need help in "doing their hair" or getting in and out of the bath-tub and some

will require aid in tying shoe-laces or getting arms into dressing gowns. The nurse should see that casts are applied comfortably at required times; also that her patients take sufficient rest and do not overtire themselves when they begin to feel better. Rest is an important part of the treatment.

From a patient's standpoint, gentleness, understanding, and cheerfulness on the part of the nurse are the most important attributes. Arthritic patients are, as a rule, of a remarkably cheerful and happy disposition no matter how hopeless their condition seems. There are bound to be times of depression when understanding on the part of the nurse is of invaluable assistance to the patient's morale.

Any effective treatment of arthritis, even in the early stages, requires several months of hospitalization. Many of the patients have to return several times for additional treatment. Thus the nurse is working with the same people over a long period of time and comes to know them well as individuals. They are victims of an insidious and relentless disease which afflicts 5 per cent of our population and which, up to the present, has been virtually neglected by medical science. Today, for the first time, research work is being stimulated and there is hope of cure or at least improvement for many of its victims. By giving her best the nurse can feel she is doing her part in this battle which is well worth fighting.

Some Allergies Said Prenatal

Many infants are sensitive to certain foods they have never eaten because they had been so sensitized before birth, states Dr. H. E. Edwards in an article—"Food Allergy"—in the Memo to Mothers section of the Health League of Canada's magazine, *Health*. Dr. Edwards is with the Hospital for Sick Children, Toronto, and the Department of Pediatrics, University of Toronto.

"This may occur when a pregnant mother gets a food craving and over-indulges," writes Dr. Edwards. "Some of this food gets into her bloodstream and through to the baby's

bloodstream and may sensitize receptive cells.

"An example of this is the finding of a baby who is sensitive to chocolate and its mother who admits the over-indulgence of chocolate during the latter months of pregnancy, either to satisfy a craving or to disguise the taste of the milk she drinks."

A change brought about by the British National Health Service is that whereas formerly pharmacists filled only some 40 per cent of all prescriptions of the medical profession, they now fill 100 per cent.

Occupational Therapy for the Chronically Ill

MARGUERITE E. STOCKER

Average reading time — 22 min. 24 sec.

BY THE TERM "chronically ill" we mean any patient, young or old, who is suffering from a prolonged illness and who will benefit from hospital care. The rise in life expectancy from 40 to 65 years, the shift of the population from rural to urban areas, housing shortages, and increased costs of living have resulted in families being unable to support any member of the family who may have become financially dependent due to illness. Thus, the hospital population is greater. These people are the community's care—local, provincial, and federal governments must all assist. We must work together as a team—doctors, nurses, physical and occupational therapists, social workers, and other allied workers—to substitute for the home and to arouse in these patients such health, happiness, and comfort that they will have a real interest in life and a zest for living. Of course, this must fall in with their active and routine medical care.

Occupational therapy may be defined as any activity, mental or physical, medically prescribed and guided, contributing to or hastening the recovery from mental or physical illness. Occupational therapy must be controlled by the doctors and watched by the nurses to ensure its contribution to the well-being of the patient. Manual occupation with mental satisfaction results in forgetfulness of physical discomfort and handicaps, zest for accomplishment, a feeling of worth, and, often, development of manual dexterity. It induces better sleeping and eating habits and a healthy outlook on life.

What can be done where there is

no occupational therapist? When the nurses realize the need for something more than routine care for a positive treatment, they might turn to the hospital auxiliary for help. If one has not already been organized, this could be a valid reason for its formation. The shopping, preparation, distribution, and teaching could be done by members of the auxiliary. It would be the nurse's responsibility to inform the workers of the patients' handicaps, precautions to be taken, best working positions, and any mental hazards to be guarded against. Also, it would be advisable for the nurse to suggest the patients' projects. She has an opportunity to observe a patient's likes, dislikes, and his capabilities much more than someone who visits him once or twice weekly. It would be her responsibility to check working time and to provide space for the storing of unfinished work. Also, if she were there when the work was being described to the patient, she could assist the patient when he or she is having difficulty.

Before I suggest actual projects, I shall mention two other factors. First of all, the *value of color* should be considered. There are so many beautiful hues of wools, felts, etc., and patients do love them!—Why not use them? They cost the same as the drab ones. Also, it is most uplifting for the patients to *go to another room to work*. If no regular O.T. workroom is provided, a pleasantly furnished sitting-room could be used. The atmosphere is much more homelike and relaxing than that of a ward. It means more to a patient than words can convey.

Volunteers go to the Junior Red Cross Children's Hospital in Calgary each Friday afternoon for two hours to teach a group of patients his or

Miss Stocker presented this paper at an annual meeting of the Alberta Association of Registered Nurses.

her particular hobby. One group is taught basketry by a volunteer from the Canadian Institute for the Blind, another ceramics, another leathercraft by a scout-master. Other groups are taught a variety of crafts by members of the Calgary Allied Arts Centre. This "Hobby Afternoon" is a big time for the children. It is easily controlled, being a regular affair and a special treat after studies all week.

A project which might easily be overlooked is education. Students, whose education has been interrupted by illness, can continue their work through the excellent help of the Correspondence School Branch of the Department of Education. Students are given full credit for work completed in their grades while attending school. We have found at Central Alberta Sanatorium that children of grades as low as "two" worry about returning to school and finding themselves behind their former classmates. The courses are well outlined and excellent supplementary reading is provided. Perhaps a former teacher in the community would volunteer to assist and encourage these children.

There are numerous correspondence schools which offer excellent courses for adults who desire to acquire learning in a new field, enrich their knowledge of their present occupation, or merely enjoy some new interest. Among the courses available are: shorthand, typing, book-keeping, accounting, salesmanship, motor mechanics, commercial art, draughting, business English, etc. For those whose position is restricted, there are excellent adjustable bed-tables. They allow the patient to type while he is lying flat on his back. The board or table is a draughting-board so it is possible for a patient to do any type of draughting, drawing, painting, as well as providing an excellent book-rest.

Simple crafts, using material that is easily obtainable and requiring little preparation, may appeal to the patients. Foremost among these is weaving. It is an ancient art. It can be simple or complicated. Patients

are advised to attempt the simple type first. Children and adults with restricted movements love "Weave-its." Ordinary knitting wool can be used on these small frames to make squares. Scarves, bags, and afghans can be made by joining the squares together. The box or cradle-type of table loom is a little more involved. Knitting wool, warp (cotton or carpet), or "Weavecraft" weaving wool may be used. Men really enjoy weaving and our patients delight in making their family tartans in scarves and materials.

Another ancient craft is needlepoint in its two forms—*gros point*, meaning a large stitch, and *petit point*, meaning a small stitch. All supplies are easily obtainable now. The work is light, fascinating, and colorful. It does require good eyesight and good lighting. Where the patients are restricted in time and effort, this is an excellent craft. We started it a year ago at the Sanatorium and no girl has been able to resist its fascination and leave without doing at least one piece.

Rug-making is a craft enjoyed by both men and women. There are two types among the many that are most practical and interesting to make. First, the donegal or turkey rug that is an all-wool yarn rug. It is expensive—materials for one rug, 2'3" x 4', cost about \$13. However, the rug will last a lifetime and can be vacuumed. This type of rug is colorful and can be made in any design or shape. No frame is required so it can be made by the patients confined to bed.

Another type of rug is the braid-woven mat. A three-strand braid of dyed silk stockings or folded cotton strips is sewn together on the reverse side. These can be most attractive. Their beauty depends upon the choice of colors used in dyeing stockings or in choosing material. A very pretty result can be obtained by dyeing a large number of stockings at once. Nylons and rayons dye different shades, which blend beautifully when braided together. Nurses' cast-off stockings are excellent for dyeing.

No equipment is necessary for this type of rug-making. They are most suitable for women to make.

Shearling toys are attractive and easy to sew together. Six toys can usually be cut from one skin. The overall cost is about \$1.30 per toy. No equipment is necessary except a needle, linen thread, and a razor blade to cut the shearling. Any small toy patterns with few pieces are suitable. We make lambs, scotties, cocker spaniels, rabbits, and bears.

Children should be given educational toys as often as possible so that they may grow mentally alert. Strings of spools or colored beads strung across cots amuse small youngsters. Cutting with blunt scissors, pasting, crayoning, folding paper, dressing dolls, etc., provide endless enjoyment. Books can be made from the crinoline off elastoplast bandages. Christmas or birthday cards make the best pictures for these small books. They are gummed to the crinoline then the pages can be sewn down the back on the sewing-machine and the edges can be pinked. These books will not tear and can be discarded when soiled without any loss. Musical records, books, studies, nursery rhymes, games, soap carving, knitting, clay work, leathercraft, and beadcraft are among the many possible suggestions for maintaining and improving mental activity and providing an outlet for pent-up physical energy among children.

Clay work, "ceramics," has increased greatly in popularity recently. Where there is no kiln or opportunity for firing clay models, "model-light" clay, a self-hardening type, is an excellent substitute. This medium of expression is excellent for arthritics. The clay is soft, not injurious to the joints, and yet it encourages mobility. It is an inexpensive craft. There is no end to the variety of objects that can be made—brooches, ear-rings, ornaments, candlesticks, vases, pictures, jugs, cups, lamps, plates, etc.

Plaster of paris makes lovely plaques. It is mixed with water, poured into a mould, and allowed to

dry and harden. Babies' rattles, split in half along the seams, make excellent forms for plaques. The plaques will fall out of the forms when they are sufficiently dry. They can be painted with water colors and shellacked with colorless nail polish. Hairpins or paper clips may be inserted while the plaster of paris is still wet, thus making hangers for the plaques, or gummed hangers may be applied when the plaques are completed. It is an extremely simple activity but there is no limit to the imagination that can be used in the painting.

Felt, also, provides many colorful and diversified activities. It is easy to handle and is a material which does not irritate arthritics. Hand-bags, knitting bags, slippers, flower ear-rings, Mexican appliqué boleros and jackets, caps, card table covers, belts, and pictures are among the articles suggested. Very attractive pull toys can be made by attaching wheels or spools to the base of felt toys.

The patients at Central Alberta Sanatorium have found uses for discarded x-ray films. They wash them clear, cut them into shapes according to pattern, put a pretty flower from a card on background paper between two layers of film. These are punched at the edges with a paper punch and crocheted together to form baskets. Doll house furniture, rectangular jewel boxes, sewing baskets, and book-marks are among the other articles that can be made in a similar manner from old film. The only expense is the crochet cotton.

Work on frames is easy and attractive to both men and women. The men make place-mats and cushion tops using cotton warp. The women also make place-mats but usually prefer dressing-table mats of faultless cotton. The shuttles for tying can be made from plastic strips or from flattened spikes. Punchwork cushion tops and bags require an 18" wooden frame, thumb tacks, an 18" square of velveteen, a pattern on cotton, and a hook. The patterns indicate the shades to be used so there is nothing difficult, yet they are colorful and

attractive. All supplies are available at needlework departments in the larger stores. This craft is popular among men.

Leathercraft is a much more difficult craft. The supplies and equipment are expensive. If there is someone on the staff or a volunteer qualified to teach it, all well and good, but do not start without sufficient knowledge. It is a wonderful craft in that it takes a lifetime to learn all that there is to know and it can be graded from very simple work to most ornate and difficult designs. Link belts, braided belts, and dog leashes are excellent projects for boys as these can be made with no equipment.

Wood-carving, to make ornaments, pictures, trays, requires only one tool—a jack-knife. If necessary, a gouge may be improvised. Pine and basswood are good materials for the beginner. A cake of soap makes an excellent practice block.

The list of possible crafts is almost limitless—silverwork, plastics, wood-working, shell work, photography, stamp collecting, story and poetry writing, embroidery, knitting, crocheting, smocking, dressmaking, fly-tying. Recreation is important, too—

active and quiet games, musical recordings, and the radio all assist to make life more enjoyable. Never forget the seasonal parties! So often a patient leaves the Sanatorium saying, "I didn't have time to do so many things that I wanted to do!"

This combination of work and play will provide a hobby for patients who are going home to convalesce. Perhaps then they can do some of the things they have seen being done and wanted to do themselves. For some their hobby becomes their vocation when they are discharged.

There are so many extremely interesting activities that the nurse who is willing to sacrifice a few minutes of her time to encourage the patients will be rewarded immeasurably. Nursing care will be easier and a happier atmosphere will prevail. We look forward to the day when there will be Occupational Therapy Departments in all hospitals. Until then, may we all remember that the patient is a whole personality. We must treat not only the physical ills but satisfy his mental needs. We must prevent mental stagnation and keep the body working to the best of its physical capacity as long as possible.

Definitions of Functions

SISTER MARIE-JEANNE TOUGAS, S.G.M., B.Sc.

Average reading time — 8 min 48 sec

THE Nursing Service Organization of the Regina Grey Nuns' Hospital has studied, at its regular meetings, the following principles of sound organization and administration:

1. There should be centralization of executive authority.
2. The lines of authority should be well defined.
3. There should be delegation of authority commensurate with the responsibility given.

4. There should be definite assignments of duties and provision for checking of duties.

5. There should exist a spirit of cooperation.

As a result of this study, an attempt was made: (1) To define the various titles as used in the institution; (2) to indicate the lines of authority and (3) the relations and the duties of the different persons employed in nursing service, namely: the director of nursing service, the supervisors, the head nurses, and the clinical nurses on general duty.

Sister Tougas is chairman of the staff program at the Regina Grey Nuns' Hospital.

DIRECTOR OF NURSING SERVICE

This is the person responsible for the organization and administration of the nursing service in the hospital.

Authority: She is responsible to the administrator. She should work closely with the director of the school of nursing and the chairman of the staff program. She has authority over supervisors, head nurses, and all department heads as far as nursing service is concerned.

Functions:

1. To make sure that the hospital provides a good quality of service.
2. To work in cooperation with all the other members employed in nursing service.
3. To maintain good relations with the medical staff on matters concerning nursing service.
4. To report to the administrator.
5. To investigate into needs of departments.
6. To report shortage of personnel and advise as to employment.
7. To see that proper working and living conditions and proper health service are available.
8. To keep records of functions of various personnel; of qualifications necessary in relation to position; of criteria used in promotion.

SUPERVISOR

A clinical supervisor is a graduate and registered nurse who is responsible for intelligent nursing care of patients, the educational development of student nurses, the work of other members of the personnel within her department, and the care of equipment and supplies.

Relationships: There should be a democratic working relationship between the supervisor, the director of nursing service, the director of the school of nursing, the clinical teachers, and the head nurses within her department. They are co-workers with the same fundamental objectives in view but, because of the broader experience and qualifications of the supervisor, she holds the senior position which is one of authority.

The supervisor should provide the type of leadership that will allow the

head nurses to fulfil their rightful responsibility in regard to the patients, the students, and the hospital, and encourage them to feel the significance and importance of their position.

The supervisor has a number of responsibilities toward: the administrator of the hospital, the patients, the members of the medical profession, the graduate nurses and the students, the community at large through patients' relatives and friends.

Qualifications:

1. The supervisor should possess sufficient "job intelligence" to perform her duties efficiently—i.e., she must possess all the necessary functioning information for the management of her clinical department.
2. She must merit the respect of those whom she is supervising; she will do this best by respecting them and never asking them to do a thing which she herself would not accept to do.
3. She must be an organizer and have executive ability.
4. She should be a helpful counsellor and a stimulating leader of her head nurses by virtue of her experience, preparation, and qualifications.
5. She must be just in her dealings with those supervised and her criticisms must be constructive.

6. She should see that facilities for carrying on the work are adequate and try to manage the whole situation at the lowest cost possible to the patient and to the hospital.

7. She should help to organize the activities of the personnel under her and develop a system that provides for the smooth, efficient running of her department day and night.

Duties: These may be classified under the following four main headings: Nursing, Management, Teaching, Housekeeping. The supervisor must:

1. Make a job analysis of the entire ward situation in order to improve all the phases from nursing to housekeeping, so that the hospital may achieve its aim.
2. Play the part of a hostess.
3. Staff the ward with the nurses sent to her and provide the proper nursing experience to student nurses.

4. Plan the work with the greatest possible degree of efficiency; make assignments; check on the performance of duties assigned and the progress made by the individual.

5. Adequately supervise the nursing care being given so that the quality will be maintained or improved.

6. Cooperate with any plan for the up-building of the hospital, the education of nurses, and be interested in the development of good methods of nursing care.

7. Have a broad professional outlook—i.e., be a student in the nursing educational field.

8. Audit the lectures which are related or which pertain to the nursing in her particular department, whenever possible.

9. Find time for personal conferences with head nurses, students, or employees.

10. Appreciate the efforts of her subordinates and acknowledge their progress by recording achievements on efficiency reports.

11. "Keep house," that is see to repairs, replacements, equipment, supplies, linen, meals, cleanliness in rooms, etc.

HEAD NURSE

She is one who shares the duties and responsibilities of the supervisor. She holds a key position in that she is the closest to the students in their practice field and is also in direct contact with the patients and medical staff. In conjunction with the supervisor, the head nurse is directly responsible for the nursing care of patients.

Relationships: There should be an understanding and cooperative relationship between the head nurse and the supervisor. The head nurse should recognize in the supervisor a person of wider experience to whom she should look for help and guidance. She must keep her supervisor informed about all the important activities and events of the department in her absence and she should cooperate in every way she can with departmental policies, regulations, studies, experiments, and other plans initiated for the improvement of the service.

Professional attitude: Because of the nature of her position, personality qualities will have a direct influence

upon the students and the patients. Her influence will tend to foster or destroy the spirit and attitude of the students in regard to nursing. From the point of view of the patient it is important that she be tolerant, sympathetic, and tactful, thus promoting a sense of confidence and security.

Professional preparation: Before assuming the position and responsibilities of a head nurse one should have preliminary experience and preparation. This preparation should comprise: (1) At least six months on staff as general duty nurse; (2) an additional six months as assistant head nurse. This preliminary preparation would be helpful in giving her a general understanding of ward administration. The essential qualifications that every institution expects to find in a head nurse are: an able manager, capable housekeeper, a skilful bedside nurse, an effective teacher, a good cooperator, as well as a person with high professional standards.

Duties: The head nurse should see that the patients are receiving the best possible nursing care. In order to do so she must know what skilful professional nursing care is, how to give it, and how to provide it for the patients. She should know all the patients individually, their needs as well as their physical condition, their treatment, medications, and the progress they are making.

The medical staff should be able to depend on her expert knowledge and skill with respect to the administration of such care. She, in turn, should be able to secure expert counsel from her supervisor as she needs it.

The assistant head nurse shares all or part of the duties and responsibilities of the head nurse.

THE STAFF NURSE

Clinical nurse on general duty is the person who performs the nursing service of a general nature in any department of the hospital.

Qualifications: The general staff nurse should be expert in administering nursing care to her patients. Her presence, attitude, and manner

of work have a definite influence upon the students with whom she comes in contact on the wards. From this point of view it is important to select graduates who have a wholesome attitude towards their work and the school.

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The Nurse and the Law

CARL LEDOUX

(Continued from June, 1950, issue)

I RECALL one case in North Vancouver some time ago, where a pedestrian was knocked down by a motorist who had been drinking. The motorist fled but was apprehended by our men. He denied the allegations made by the police and stoutly asserted that he had not struck anyone, despite the fact that his headlights and windshield were broken. In order to supplement other evidence, the victim's coat was sent to our laboratory where it was minutely examined for paint or glass fragments. No paint was found but there were some tiny particles of glass. Pieces of the windshield and headlights of the suspect car were sent over for spectrographic analysis. This proved negative. Neither windshield nor headlight glass corresponded to the fragments found on the coat. A radio message was sent to North Vancouver, inquiring if there had been any other glass on the car in question. Immediately a reply was received that the only other glass was in the motor-meter, a type of thermometer mounted on the radiator of old model cars. It was sent over and tests showed this glass to be identical with that found on the victim's coat. A conviction resulted.

I recall a case I had in Chilliwack a number of years ago. A man and his wife were struck down while walking on a dark highway west of that city. The victims were taken to the hospital at Chilliwack by a passing motorist and I was advised. At the hospital I gained possession of the victims' clothing for inspection. A quick check was made and from information received the suspects were narrowed down to a small number. Inquiry at the home of one of these showed that he was in bed and apparently had been home for hours. Not quite satisfied I went to the garage and found the radiator of his car still quite hot. The exhaust pipe was still warm, indicating the vehicle had been recently used. Further examination showed that the car had been recently painted with cheap enamel. While quite dry the paint had not "set" properly and could be indented with the finger-nail. I examined the front of the two fenders closely and located an area where the soft paint had been "engraved" with the pattern of a piece of cloth. There were several fibres embedded in the paint and these corresponded to the coat removed from the male victim.

The pattern of warp and weft, or the weave of the cloth, matched the engraving. In view of the evidence against him, the culprit admitted his offence and pleaded "guilty" when charged.

Another case I recall was when a Chinese was brought to one of our Vancouver Island hospitals, suffering from injuries received in a mining accident. His clothes were filthy, ragged, and torn by a blast of dynamite. When removed, they were taken out to the back but, fortunately, not burned. Instead, they were hung on a line. Some time later, some of the patient's friends, after visiting him, asked the nurses where his money was. They were very much surprised to find that the Chinese had been carrying \$600 on his person when working, as he had no other place to keep his money and did not believe in banks. They at once went to the clothes-line and retrieved the disintegrating pair of trousers in which they found the entire \$600 quite intact.

In cases of homicide or assaults of a murderous character, clothing plays a very important role. For instance, bullet holes may tell a story. There are means of estimating the distance from which a fire-arm was fired by the powder pattern on clothing or flesh or, in the case of a shot-gun blast, by the area covered by the pellets. This may be very important in showing whether the shooting was in self-defence or with murderous intent.

There is one case in which I assisted a couple of years ago which illustrates this point. A man was charged with attempted murder after shooting his stepson. The culprit claimed that the boy had shot himself while they were struggling over the possession of a gun with which the boy had threatened his stepfather. The boy's story was quite different. He stated that his stepfather had lain in wait for him and shot from a distance of perhaps ten or twelve feet without warning. The boy had then closed with his assailant and, wounded as he was, wrested the gun away from his stepfather, knocked him out, and phoned

for the police before fainting away.

Here was a case of one man's word against another's, and the prosecution was faced with the legal maxim that the accused must be given the benefit of any reasonable doubt. It was quite evident that some expert evidence would be required to determine the actual distance from which the shot had been fired. The pattern of shot-gun pellets on the boy's back covered a certain well defined area. As you all know, a charge of buck-shot fired from a shot-gun assumes a cone shape, widening as it travels farther and farther from the muzzle of the weapon. Working on this principle, our ballistics expert made a series of tests with the fire-arm in question. Identical shells were used and a series of test shots were made at distances from one-half inch up to fifteen feet from the muzzle. From these test shots, a chart was prepared showing the cone of fire. Consultation of this chart showed that the minimum distance between the gun muzzle and the boy's back must have been at least eight feet and probably much more. This entirely negated the culprit's assertion of self-defence. The ballistic evidence, coupled with the other facts of the case, resulted in a conviction and a sentence of twenty years at hard labor. The culprit had a criminal record and had been married a number of times, most of his wives disappearing inexplicably.

While there are many cases of this kind which could be told, the foregoing will serve to illustrate my point. Suffice it to say that clothing is frequently of paramount importance to the proper presentation of a criminal case. Every care should be taken in the preservation of garments. If wet, they should be dried by normal means, excessive heat being avoided as this may destroy evidentiary material. Clothing should not be allowed to remain wet. Wet blood tends to putrefy but keeps indefinitely when dry. There may be some stains on a garment which are not the victim's blood. Those stains are possibly due to some injury sustained by the attacker and, therefore, if sufficiently

preserved to make a blood group determination would be of great value as evidence.

When a patient is being undressed preparatory to surgical or other treatment and it is impossible to remove the clothing by normal means, it is suggested that *the seams of the clothing be ripped*, instead of cutting the clothes off indiscriminately with a pair of scissors. The latter course may destroy invaluable evidence which can never be restored.

Some notation should be made of the time, date, and place when garments come into your possession. They should be handled by as few people as possible so that the "chain of evidence" will not involve many witnesses to prove the continuity of possession.

Notation should be made of the condition of the garments when they come into your possession, such as whether wet, or soaked with blood, covered with dust, caked with mud, and so on. Searching clothes should be left to a competent investigator who will be better equipped to locate possible evidence and preserve it for future use. When the garment is dry, it should be placed in a paper bag provided for this purpose. In this way, any small amount of hair or fibres or perhaps minute particles of vegetation, soil, or gravel, adhering to the clothing, will be preserved for examination.

Another very important point I would like to draw to your attention is the recovery of fatal bullets. Occasionally a person is shot with a low velocity projectile or one that has travelled a considerable distance. The bullet may have sufficient energy to penetrate the clothes and skin of the victim, then travel right through his body to emerge from the other side. However, the last bit of energy may have been expended in passing through the final layer of skin. And so, instead of going right through the victim's garments, it will drop between skin and underclothes. When the patient is disrobed, the bullet will probably roll unnoticed to the floor and be swept away. So another valuable

piece of evidence is lost completely.

Where there is an exit wound on the patient, and no corresponding hole in the garments, great care should be taken to avoid losing the valuable projectile. In one case that I recall, a bullet was lost in this manner. They hunted high and low but were unable to locate it. Finally, giving up, the clothes were put away. One of the officers noticed something rattling in a shoe, reached in, and there found the missing bullet. It had wormed its way down through the victim's underwear and into his sock, thence through a hole into the shoe.

Perhaps a word or two regarding bullets and their use as evidence in cases of gunshot wounds would be valuable. Every fire-arm of the rifled variety has a definite pattern or engraving inside the barrel which is peculiar to that particular weapon and no other. This is caused by the tool marks left in the barrel when the weapon is rifled. The minute scratches are impossible to duplicate and the pattern changes as the tool wears away with every cutting. When a soft lead bullet or even a hard-cased bullet is fired through the barrel, it acquires the pattern of scratches of that particular weapon. An expert in fire-arms examination may then determine whether or not a fatal bullet was fired from a given weapon. As the engravings are microscopic, it is very necessary that the bullet be kept free from all damage and that it should under no circumstance be removed from a body with forceps or other metallic means if this is avoidable. The instrument will flatten the delicate pattern and render the bullet useless as a major piece of evidence.

Great care, then, should be taken in handling bullets found in or about the body of a shooting victim. They should be preserved in a small vial or pill-box with a little cotton wool. Again there should be a record of the time, date, and place where the bullet was recovered and, of course, if the physician or autopsist removes the bullet from the body he will also have complete notes on its original position in the victim and the course it took.

The care of metal fragments does not only apply to bullets but many other pieces of metal may be of prime importance. For instance, in United States records there is a case of where the victim of a hit-and-run accident was brought into hospital for treatment. He died and in the autopsy that followed it was found that an automobile curtain stud, such as was used on old-fashioned touring cars, was embedded in his head. This stud, which has a similar appearance to a 22-calibre bullet, though smaller, had entered the skull sideways and left a perfect pattern of its profile. Later the stud was valuable in proving the identity of the hit-and-run car.

It is very difficult to advise you what to look for in any such accident or injury. All cases differ and I can only give you a brief outline of points which may arouse your interest and prompt you to observation when the circumstances warrant. Many of the points which I have mentioned and which I will discuss are perhaps in the autopsist's field, but there is no harm in your also learning what may be of use in evidence.

Foreign material in a wound can be of major importance, proving that a certain contaminated instrument was used or perhaps indicating where the assault took place. The contents of the stomach, though devoid of poison, may give a great deal of valuable evidence. That reminds me of a case in Boston some time ago. A young woman was found dead on a park bench. She had been strangled but there was absolutely no evidence either of her assailant or of her identity. The medical examiner ascertained from the temperature of her body, and other post-mortem indicia, that she had not been dead over an hour when discovered. As the body had been found around 7:30 p.m., the medical examiner reasoned that the victim should have some indication in her stomach contents of what and when she had last eaten, which might be of value in tracing her movements. A post-mortem was done at once.

The contents of the stomach re-

vealed much more than the medical examiner had expected. There was evidence that the victim had consumed a meal within a half-hour or so of the time she met her death. The meal had been one cooked in the Italian style and had contained such material and condiments as ravioli, green peppers, celery, ripe olives, and raisins. With this information a canvass was made of all the restaurants in Boston which served meals of this kind. The investigating officers interviewed the waitresses and asked them whether they had served a young woman of the victim's description with such a meal within the last couple of hours. Finally one girl was found who thought she had served the victim. On being brought to the morgue, this was confirmed by her definite identification of the victim. However, she did not know the girl, in fact she had never seen her before that night. The victim had dined in the restaurant with a man but the waitress did not know him either. On being further questioned, the girl recalled that the man had eaten in the cafe on a previous occasion with another man whom she did know. The police were not long in following up this clue with the result that the assailant was in custody within twelve hours of the murder.

To return to our discussion, anything which the victim of an assault or other form of crime involving the person has with him, or about him, should be safeguarded. A cigarette case or a pocket flask, or perhaps a mirror, may have the assailant's finger-prints on it. *Don't*, as they do in the movies, *carefully wrap the article in a handkerchief and put it away*. This is the surest way of obliterating the entire latent finger-print, or at least in blurring it to the point where it will be valueless as a means of identification. The article should be placed in a receptacle where the suspected surfaces will not come into contact with anything at all.

When preparing a person for medical care, attention should be given to his or her hands. They may be cut or scratched when the victim attempt-

ted to defend himself, and thus indicate the type of weapon used in the assault. Again in fighting off the attack, the victim may have scratched or gouged the attacker's face or hands. There may be tiny fragments of epidermis under the finger-nails or even flecks of blood.

Where we find dead bodies showing marks of criminal assault, one of the first things we do is to remove the finger-nail scrapings and preserve them for later examination. Quite often there may be a hair or two which will be of assistance in identifying the culprit. A great deal may be learned from a single hair. An estimate can be made of the race, whether male or female, whether it comes from the head or elsewhere and, perhaps, how recently it has been cut. If the hair is pulled out by the root, additional information may be secured. You will see, therefore, that a single hair may be a big help in the solution of a crime.

A rather unusual, but nevertheless interesting, factor in the examination of victims of homicidal violence is the presence of teeth marks. If such marks are found, they should be drawn to the investigator's attention. They can be photographed and thus preserved. If they are of a peculiar character or pattern, they may later be identified with the assailant's denture, thus adding another piece of evidence to the case.

In at least one occurrence I know of, lipstick marks told a story of murder. This case happened in the eastern United States some time ago. A young woman was occupying a room in a hotel. The chambermaid came around in the morning to tidy up the room but found the occupant apparently fast asleep. The maid retired quietly. Some time later, the maid returned to the room, knocked

and, receiving no reply, opened the door. She found the sleeper in identically the same position, so she stepped up to the bed and took a closer look. The woman was dead!

Hurrying to the hotel office, the maid babbled out a story of finding a dead woman in room so-and-so. The hotel clerk at once sent for the police who in turn notified the medical examiner. A routine investigation was made. It appeared that the young woman had died of natural causes and the medical examiner was just about to leave when he detected small hemorrhages in the whites of the eyes close to the nose. They were very slight and a few hours of post-mortem change would no doubt have obliterated them entirely. These, however, made him suspicious and he carefully examined the bed. He found it quite orderly. No sign of a struggle, nor were there any bruises about the dead woman's body. But, in turning over one pillow, he found a lipstick stain in the centre. This stain was the full-bodied impression of two lips and was of the same color as the lipstick used by the dead woman. The impression was so clear that it indicated the pillow had been pressed hard against the mouth. Here was evidence of foul play.

The woman was not identified at the moment, having registered under an assumed name. A box of sedative capsules was found in her effects. The name of the drugstore was obtained from it and the prescription traced to her family physician who was able to supply the missing information. It appeared that the young woman was married but lived apart from her husband whom she met occasionally. The husband was located and confessed to suffocating his wife. A crime solved through vigilance for detail.

(To be concluded next month)

The sky is actually colorless. The beautiful colors, which we see in the heavens, are caused by the reflection and refraction of the sun's rays by the infinite number of dust particles scattered throughout the atmosphere.

Public Health Nursing

Camping for Crippled Children

GRETTA M. ROSS

Average reading time — 8 min. 24 sec.

A GENTLEMAN truly interested in child welfare was once invited to visit a camp for crippled children. He accepted but his reply inferred that he was not particularly thrilled by the prospect. He felt that it might be a depressing place—not only for visitors but for the children themselves.

However, he came—he saw—and was conquered! His comment was similar to that of all visitors, who say with surprise and conviction—"How happy all these children are!"

Let us look for the reason. In all camping the general aims stressed are:

1. The development of physical, mental, and spiritual health.
2. Special skills.

Miss Ross is director of nursing and camps with the Ontario Society for Crippled Children

3. Love of the out-of-doors.

4. Social adjustment.

If these four aims be important for the normal child, how much more important must they be for the crippled child who, because of his handicap, cannot participate in so many activities taken for granted by the normal child.

So often a crippled child is deprived of real companionship with those of his own age group. His horizon is a narrow one. A camping experience gives him this companionship and widens his horizon. He is surprised to discover that the activities here are the same as those of the camp of which his physically fit pal has been bragging for years. He is thrilled to find that here he can participate in all these activities.

This holiday gives him all these things in abundance: sports, games, arts and crafts, swimming, dramatics,



Blue Mountain Lodge

Globe & Mail Photo

music, folk-lore, nature study, camp-fires, etc. From a program of this kind, the handicapped child benefits greatly but still of greatest importance is his social adjustment.

The Ontario Society for Crippled Children has three camps. "Blue Mountain" on the shore of Georgian Bay, five miles west of Collingwood, Ont., was opened in 1937. It is ideal for the purpose with a wide expanse of water and sand and the ever-changing Blue Mountain in the distance.

"Woodeden," seven miles west of London, was opened in 1946 and is best described by an excerpt from an article written by Elliott Dickinson and published in *Forest and Outdoors* under the title of "Woodeden—Castle of Childhood":

Straight out of a picture book, a few miles west of the forest city of London, Ont., stands "Woodeden." Characteristic of its lovely name, it is set in the curve of the Oxbo Creek and in the fold of the gentle hills. Nowhere has Nature been so lavish. Unobtrusive and quiet, its beauty is as simple in its appeal as the light and shadow that perpetually fill its generous acres.

Equally beautiful is "Merrywood-on-the-Rideau" on Rideau Lake between Perth and Smiths Falls, Ont., opened in 1948. This large estate, with its green lawns sloping to the water's edge, its maple grove and extensive grounds, provides an ideal location for crippled children.

These three camps serve south-western and eastern Ontario and together make it possible for approximately 450 children to enjoy a three weeks' holiday under ideal conditions.

There are in Ontario many other handicapped children who would benefit from such an experience, and it is hoped that in the not-too-distant future a camp may be established to serve the children in the northern part of the province.

The staff of each of the camps consists of the following personnel:

Camp director, two nurses, house-keeper, program director, swimming instructor, six voluntary counsellors, arts and crafts instructor, cook and

assistant cook, three kitchen counsellors, one kitchen boy, two handy boys, caretaker.

At all camps 4 groups each remain 3 weeks: Boys 5 to 12 years of age and boys 12 to 16; girls 5 to 12 and girls 12 to 18 years. The child accepted may be from one of three groups:

1. The crippled child who has no means of obtaining a camp holiday, either because of lack of facilities or finances.

2. The child who is too crippled to go to any other camp. There may be no financial difficulty in this case.

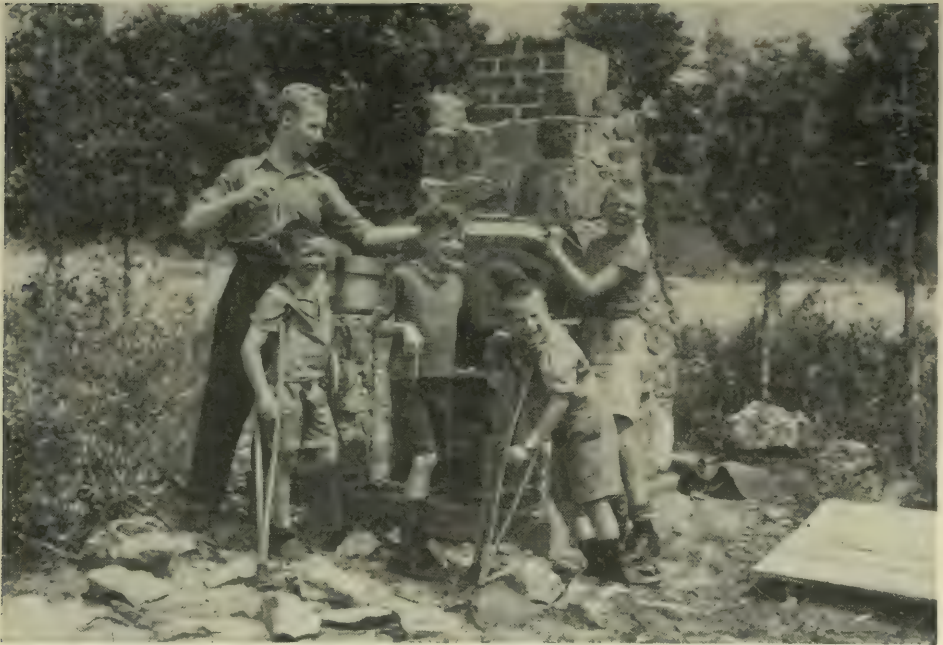
3. The child who, for some special reason, such as association with other handicapped children, needs a specialized camp of this kind.

It is most interesting to observe the reactions of children attending camp for the first time. Home-sickness is rarely a problem. It may be accentuated by the weariness of a long trip but it is soon cured by understanding staff and cabin friendships.

Two little friends, six-year-old girls, victims of cerebral palsy, took their first steps at camp as a result of the efforts of two counsellors who, by a little competition, succeeded in stimulating both children to greater efforts. Similarly, an older camper, who had been overprotected all her life, learned to wait upon herself when her cabin friends refused, with the frank comment, "Get it yourself—you're just as good as we are!"

One is reminded of a new camper, a boy of 12, a sad-looking little man. David was a spina bifida with complete paralysis from the waist down. He came from a home where he had received very good care. He was intelligent and realized that the outlook for the future was a gloomy one. On his second day, he cheerily called the nurse with a new note in his voice and said brightly, "Gee, nurse, I'm lucky! I never knew I was lucky till I came to this camp. I might have been just like Bill!" Bill, a cabin pal and a severe athetoid with speech difficulty, told the nurse confidentially how glad he was not to have David's trouble and "have to sit on a cart all his life."

Many instances of this nature are



Around the barbecue

Turofsky, Toronto

seen and some have far-reaching results. One of the most outstanding is that of a charming little girl, a post-polio, who was referred to camp by her orthopedic surgeon. This child's home conditions were good and she had received excellent care. She was exceedingly fond of sports and found herself, after a year, still on a frame unable to walk and with considerable weakness of back and arm muscles.

The future appeared very dark to this "teen-ager" when she arrived at camp. For the first few days she was listless and uncommunicative, taking little interest in her surroundings. A cabin friend—a cerebral palsy with multiple handicaps—was struggling across the beach, when Jane, from her polio cart, said to the nurse, "I guess it's not so bad to be on a cart. I'd hate to be like Esther!"

From that day there appeared a decided change in Jane's attitude. Her appetite improved and she became more interested in the troubles of others and less in her own. This girl came back to camp for several years, at first off her frame only for part-time, using crutches and wearing

two leg braces and a back brace. Gradually these were discarded until she walked only with a cane.

Later this girl was able to attend university, graduating in social science. She has a pleasing personality, is well adjusted, and now has a position with a social agency where, due to the understanding gained in her own childhood experience, she will doubtless make a valuable contribution.

A determined effort is made by all members of staff to carry out a program following as closely as possible that of a camp for normal children. One finds the campers ready and keen to participate in all types of activity. They appreciate the attitude of the staff, who consistently stress the positive rather than the negative, encouraging their efforts and praising their accomplishments.

All cannot swim or learn to swim but practically all are taken into the water and enjoy the fun. One sees many of the happy gang being wheeled into the water on carts and even carried in on stretchers.

Campers are divided into groups

such as Hurons, Algonquins, Iroquois, etc., according to age and also degree of disability. This facilitates the ease with which a well-planned and co-ordinated camp program may be carried out.

Qualities of leadership soon become apparent among campers and those so endowed are pleased to be given the opportunity of assisting various members of staff. The severely handicapped boy soon finds a buddy who protects his interests and the slightly handicapped little girl finds another child who becomes her special charge.

With the exception of the enforced period of rest which is not too popular, activities are much the same as those of other camps—carried out with variations and with much of the planning being done by the campers. Baseball and boxing are two main interests of the boys. The boy with the strong arms bats a good ball from his wheel-chair, while his buddy with the good legs does the running for him. Excitement runs high especially among the wheel-chair referees who do not hesitate to stop the game at the least infraction of rules.

The young boxer, who has been coached by the program director, does his best but his opponent shows no mercy. The activities of the world of sport are well known to these lads, quiz programs on sports being a favorite pastime. "Cook-out" suppers are thoroughly enjoyed and, strange as it may seem, "over-nights" with "cook-out" breakfasts were successfully carried out, with quite severely handicapped children, last summer.

Approaching the end of each camp period, the final banquet is an important event, the campers being allowed to plan many of the details. The older boys may decide upon a "Lumbermen's Party," with a menu suitable for a lumber camp. Decorations, place-cards, favors, etc., are made by the children in arts and crafts period. One enters a dining-room which has been transformed into a woodland scene of logs, cedars, etc. Lights are dim, candles in log-holders, small axes, saws, etc., appear

as favors. The boy chosen by his pals as the "best all-round camper" acts as chairman. Toasts are proposed by the campers, pennants and shields are presented, speeches are made, and the evening is one long to be remembered by campers and friends privileged to attend.

Campers frequently request a dance even though many of their number may not be able to participate. "Woodedden" is privileged in having several local bands which come to the camp and provide evenings of dance music. Popular music and peppy musicians are two essentials of camp. Singing is heard daily and evening programs always end in a lusty sing-song.

Dramatics are exceedingly important and provide an opportunity for each camper to participate in some way. Days are spent in preparation for these events, the costumes, properties, etc., being made by the children under counsellors' supervision with rehearsals worked in somehow, until the great night finally arrives.

Guests arrive from the nearest centre. The last bit of make-up is applied, the curtain rises, the foot-lights glitter, and one sees the cast arrayed in all its glory. The audience is amazed and the clapping is loud and long.

Jennie sings from her wheel-chair; Mary with her speech defect proudly speaks her lines. The jokes are really good and the play runs smoothly. Suddenly, something happens to Annie—the bright, little leading lady with the merry eyes. Her leg braces become tangled; she stumbles and falls headlong. Visitors gasp and look aghast at the staff, who sit apparently unmoved. Annie lifts her head—her pals shriek with laughter; Annie chuckles, scrambles up and goes on.

Yes, "The Play Goes On," and that is what we must not forget. Many of the physical handicaps must remain but much can be done to improve the mental attitude. We must not forget that many a kindly meant comment may "cut to the quick." These children do not want pity; they hate it. As Dr. Carlson has said in

his book "Born That Way," the crippled child prefers to be laughed at rather than be pitied, and at camp we see many evidences of the truth of this statement.

May I quote from a letter of a young staff member, following his first summer at camp:

For the first time, I fully realized that what is of real worth in a person is not his appearance, it is not his physical capabilities—it is the influencing of people. What really counts is that deep and abiding thing called character. They have it and I am proud to count them as my friends.

The Battle Against Leprosy

HELEN AST

Average reading time — 5 min. 24 sec.

To all those infected with leprosy, whose number is estimated at seven million, the tremendous progress recorded in the fields of medical and pharmaceutical research has brought new hope. Since approximately a million-and-a-half of these lepers live in Commonwealth territories (including India the number was formerly about three million) it is natural that Britain should have made an outstanding contribution to this achievement. Intensive research, comprising experiments with new drugs, has been carried out in both Britain and overseas. With a view to preventing the spread of the disease, much was done on the spot to enlighten and educate the native population. Steps were taken to protect the children from infection, to improve living conditions generally, and to encourage the patients to make voluntary use of medical facilities provided.

When Sir Leonard Rogers, a member of the Indian Medical Service, began to use injections of chaulmoogra, or hypnocarpus oil, the only known method of treating the affliction was the internal use of that oil. The injections were to a large extent effective. A decisive improvement did not occur until the American drugs, Promin and Diasone, were developed. These were followed by another preparation belonging to the group of the sulfone compounds: Sulfatrone. In the short time since its introduction, this drug has proved invaluable in the treatment of malignant cases, more especially because of its less harmful side-effects on the general condition of the patient. It is, therefore, now

almost the only drug used in the Commonwealth areas concerned.

So much for the drugs. The best of these cannot be relied upon to effect a complete cure and thus be instrumental in eradicating the scourge, unless the treatment is organized, in accordance with modern ideas, on a humanitarian basis. The many experiments undertaken have demonstrated that, as in the treatment of tuberculosis, the chances of success are small if the segregation of the patients is enforced without taking into account the psychological factor. Work, pastimes, and entertainment are, therefore, provided for the patients: sports, games, music, books and, for children, schools. Wherever possible, without the risk of infection to others, the patients are even permitted to visit their families. Agricultural settlements occupied by lepers are no longer something new. The inhabitants work in the fields and in the garden, earning their keep. In some cases they have built whole villages, in which the dwellings are cleaner and more comfortable than the homes they have been compelled to leave. In a word, the inhabitants of these settlements go about their work in the knowledge that they are not outcasts, but useful members of society—a state of mind without which there could be no hope of a permanent cure.

An exceptionally optimistic report was issued recently by the leprosarium in Mahaica, British Guiana, to the effect that, in ten years' time, the scourge will probably have ceased to exist in that territory. Thanks to the cooperation of an enlightened native population, the establishment has acquired

(Turn to page 561)

The United Kingdom Information Office provided the material contained in this article.

A Study of Congenital Heart Disease by Cardiac Catheterization *

B. C. BROWN, M.D. (a), N. J. ENGLAND, M.D. (b),
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Average reading time — 18 min. 24 sec.

THE PROCEDURE of cardiac catheterization is being adopted widely, both as an aid in the diagnosis of congenital heart disease^{1, 2} and in the study of circulatory dynamics. Although Forsman demonstrated the feasibility of catheterization of the right auricle through a peripheral vein, it was not until the publication in 1940 of the cardio-dynamic studies by Cournand and Ranges³ that the procedure was shown to be practical and safe. It is fitting that the first publication of the study and diagnosis of congenital heart disease by cardiac catheterization in Canada should emanate from Montreal.

It was felt that this method was applicable for the diagnosis of congenital heart disease being encountered in the Heart Clinic and on the wards of Westminster Hospital. It was likewise felt that knowledge of

functional capacity and prognosis of certain types of congenital heart disease could be increased, since these men had fought in a war and in the majority of instances were now gainfully employed.

Our technique of catheterization is similar to that described by Johnson and associates.¹ Preliminary sedation of morphine gr. $\frac{1}{4}$ and nembutal gr. 3 were administered routinely one hour before the procedure was commenced. A cut-down was made on the left median basilic vein and a Cournand catheter was introduced. Heparinized saline solution was continuously infused during the procedure of a concentration of 10,000 units (1 ampoule per litre of saline). By a three-way stop-cock this was connected with a saline manometer, the zero pressure point being taken as 4 cm. below the xiphoid with the patient in the dorsal recumbent position. This arrangement was suggested by Dr. D. W. B. Johnston and appears to approximate the method of McMichael and associates.³

The catheter was advanced under fluoroscopic control and in each instance an effort was made to catheterize the pulmonary artery. In our first four patients, a size No. 10 Cournand catheter was used. It was technically impossible to catheterize the pulmonary artery with this catheter. In all subsequent cases a No. 8 catheter was used and pulmonary artery catheterization was rendered relatively easy. We have not found the use of a curved tip catheter to be necessary, although it may make intra-cardiac exploration easier. Pressures have been taken from the peripheral pulmonary artery circulation; the main pulmonary

* This study was carried out in the Heart Clinic and wards of the Westminster Hospital, Department of Veterans Affairs, London, Ont.

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Journal* (60, 50-54, 1949).

artery; each chamber of the heart entered and the superior vena cava only. Blood samples have been withdrawn from these sites, placed under oil and the blood oxygen content determined by the method of Roughton and Scholander.⁴ In two cases the results have been checked with the Van Slyke by one of us (N.J.E.) with close agreement throughout between the results. We have felt that with suitable correction of temperature and barometric readings this method is suitable for our studies.

This series comprises 20 cases. Congenital heart disease was suspected but not verified in 9 instances. Of the remainder, septal defects were found in 5; ductus arteriosus in 2, suspected in 2 more; Eisenmenger's complex in one and in one a wandering pacemaker without other congenital abnormalities.

An unusual finding in this series is the persistence of the left superior vena cava which was encountered three times in these 20 cases. This defect, in our experience, has never occurred alone but was associated in one with trilobular heart; in 2 with ductus arteriosus. In one case a double kidney was present. It is likewise of interest that there were but two cases with congenital heart defects which showed a single defect to be present. One of these was ductus arteriosus, the other an interauricular septal defect. This bears out the well established fact that congenital defects in the heart are usually multiple. In one very unusual instance (*see Fig. 4*) a right pulmonary vein was found to empty into the right auricle or into

the superior vena cava. It was of interest that in this case septal defect was clinically suspected and that catheterization bore out the impression of arterialization of blood in the right chambers of the heart.

Three interauricular septal defects have been studied. In only one instance⁵ was radiographic appearance characteristic. Another presented an associated interventricular septal defect. In the third, a ductus arteriosus was present. However, interauricular septal defect, functionally patent, may be present without producing the characteristic x-ray silhouette.⁶

Burwell⁷ found the blood aspirated from a peripheral branch of the pulmonary artery to be considerably oxygen enriched. We have verified this observation repeatedly in the absence of ductus arteriosus. Although we have figures for but three examples of persistent ductus arteriosus, it was found that the blood aspirated from the peripheral branch of the pulmonary artery was not richer in oxygen than that aspirated from the main branch of the pulmonary artery. We submit this observation as one requiring further study, since it would suggest certain attributes in the normal pulmonary circulation. Our explanation of this phenomenon is that with respiration there is normally an ebb and flow in the pulmonary circulation. The presence of ductus arteriosus, introducing as it does the high systemic pressure into the pulmonary circulation, renders the blood flow through the lung continuous. This further suggests "central origin," for

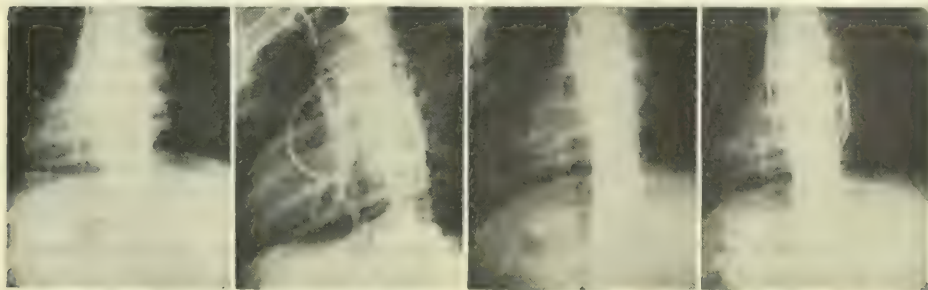


Fig. 1.—(a) Catheter tip in left posterior cardiac pulmonary artery, having entered heart through left superior vena cava—right anterior oblique position. (b) Same as (a), showing catheter in the posterior pulmonary vein. (c) Catheter in right ventricular apex with catheter looped up into right superior vena cava. (d) Same as (c) following straightening out of the loop

some at least, of the cyanosis seen after exercise in the presence of ductus arteriosus.

CASE 1

(Patent ductus arteriosus: persistent left superior vena cava)

This male, aged 26, had led an active life without illness of any moment. The presence of a patent ductus arteriosus was diagnosed in 1941. He was permitted to do heavy duty as a stretcher bearer in combat. He developed dyspnea, dull mid-thoracic pain, and was unable to carry on. He was demobilized from the army and was able to perform less strenuous duties. Upon returning to work as a carpenter, he noted recurrence of retrosternal, dull pain, and exertional dyspnea with any form of strenuous exertion.

Examination revealed a small, well-nourished male without cyanosis or clubbing. There is congenital absence of the nail on both 5th fingers and both 5th toes. Radiologically, frontal sinuses are absent. The resting pulse was 80 with a fair exercise tolerance. Blood pressure 110/70 with no change upon exercise. The heart was normal in size. A thrill was palpable in the 2nd left interspace. A typical "machinery" murmur was heard over this area, transmitted over the precordium and toward the left shoulder, and heard with grade 2 intensity at the level of the spine of the left scapula. The lung fields were clear and there was no enlargement of the liver or ankle edema.

Teleo-roentgenogram showed a filling in of the cardiac waist without hilar dance but with prominence of the main pulmonary vessels. The electrocardiogram showed no axis deviation or conduction disturbance. Cardiac catheterization result is shown in Table I:

TABLE I
Pressure Oscillation Oxygen

	Pressure	Oscillation	Oxygen
Left pulmonary artery.....	12.0 cm.	1 mm.	17.0 vol. %
Main pulmonary artery...	11.5 cm.	1 mm.	17.0 vol. %
Right ventricle.	9.5 cm.	3 mm.	6.9 vol. %
Right auricle...	1.0 cm.	1 mm.	12.7 vol. %
Superior vena cava left.....	4.0 cm.	...	15.8 vol. %

It is noted that the blood in the periphery of the left pulmonary artery has the same oxygen content as has the blood in the main pulmonary artery. This is markedly increased over the concentra-

tion in the right ventricle, suggesting that the ductus is large. It may be pointed out here, that upon this observation we postulate the theory that the presence of a patent ductus arteriosus produces pronounced acceleration in the pulmonary circulation and loss of the normal reflux. The oxygen saturations from the left superior vena cava are of interest. In this particular case the catheter passed through the left superior vena cava only on deep inspiration. Anatomically it should be remembered that the catheter must pass through the coronary sinus when traversing the left superior vena cava to enter the right auricle.* It is possible that the values called "right auricle" may represent blood obtained from the coronary sinus itself or from the right auricle immediately adjacent to the entrance of the coronary sinus. This would account for the higher oxygen concentrations obtained in the venous blood and the right auricle than that from the right ventricle.

This man's ductus arteriosus was successfully ligated by Dr. A. J. Grace. Further observations will be made to determine the alteration in pulmonary hemodynamics.

CASE 2

(Eisenmenger Complex)

This 28-year-old male had been a Japanese prisoner-of-war and was examined in our Heart Clinic in October, 1946. He had not been a blue baby. His development was quite normal. There have been no significant illnesses apart from treatment for lues in 1943. He is unable to do light work at the present time because of exertional dyspnea; left thoracic oppression and weakness in the legs.

He was a thin, poorly developed, small male with flushed cheeks, nose and ears; cyanosis of the mucous membranes and slight clubbing of the fingers. Blood pressure was 130/94; pulse 84. Transverse lie of the heart was noted with filling of the cardiac waist. A systolic click was heard in the left parasternal line in the 4th interspace with a sharp pulmonary second sound. This becomes a grade 3 rough systolic murmur with systolic thrill and a diastolic shock. After exercise a protodiastolic gallop rhythm developed at the apex. The ocular fundi revealed full

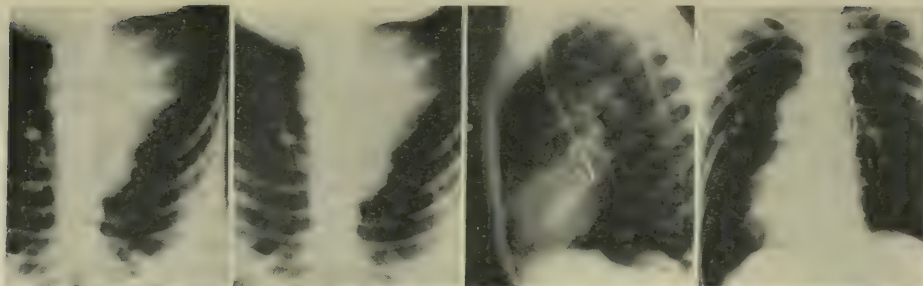


Fig. 2. —(a) Catheter in apical portion of right ventricle, which appeared to be enlarged longitudinally. (b) Catheter tip in region of ampullary part of right ventricle, lying adjacent to interventricular septum. (c) Subsequent examination several months later—catheter tip in a right pulmonary vein, having passed through an interauricular septal defect. (d) Same as (c)—lateral position.

veins. The lung fields were clear and liver not enlarged. There was no ankle edema. The x-ray showed enlarged heart with a prominent pulmonary conus.

The electrocardiogram showed right axis deviation of high degree with S-T segment depression and a sharply negative T in Lead CR4. The urinalysis was normal; hematocrit 63.1 and Kahn negative.

nosis and clubbing. Patient complained of slight limitation of exercise tolerance in extremes but has been surprisingly active for one so cyanosed. It may be of significance that she is repeating Grade 3 at school.

Clinical examination revealed a heart at the upper limits of normal in size with blood pressure 110/82; a pulse of 90 and an impaired exercise tolerance. No murmurs were elicited. Auscultation revealed a double first sound at the apex. Teleoroentgenogram revealed a globular heart with a broad superior mediastinum. The electrocardiogram showed low voltage with a broad large P and a diphasic T in Lead CR4. Cardiac catheterization was performed under nembutal sedation. The catheter met an obstruction in the root of the neck and finally passed down a persistent left superior vena cava. Further progress of the catheter resulted in the production of a large coil in the right auricle and ejection of the catheter

TABLE II

	Pressure	Oscillation	Oxygen
Pulmonary artery			
Right ventricle....	4.5 cm.	2 mm.	16.0
(apex)			
Left ventricle....	55.0 cm.*	20 mm.	21.1
Right auricle....	3.5 cm.	3 mm.	16.9
Superior vena			
cava.....	2.5 cm.	3 mm.	13.9
*(or at interventricular septal defect)			

CASE 3

(*Triloculare biatrium*)

This nine-year old girl, seen through the courtesy of Drs. Little, Bartram and McLachlin, exhibited well-marked cya-

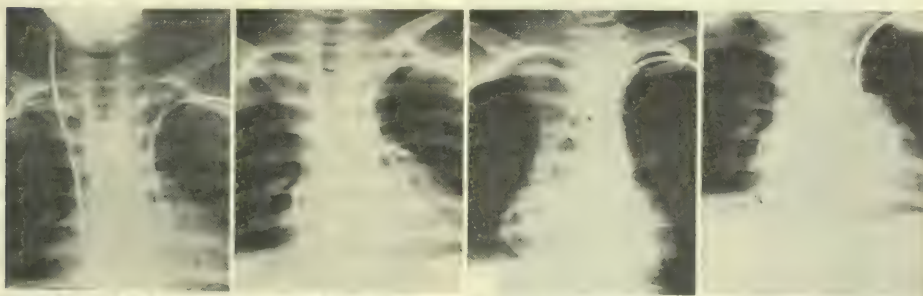


Fig. 3. —(a) The catheter enters the heart through a persistent left superior vena cava, traversing the large displaced right auricle across the mid-line and enters the right superior vena cava. (b) Catheter tip lying in the region of the left main pulmonary artery. (c) Catheter tip in left ventricular apex (slight left anterior oblique rotation). (d) Catheter tip in right main pulmonary vein to lower lobe, having passed through left ventricle, mitral valve, and main pulmonary vein.

into the persistent right superior vena cava. In all, the pulmonary artery, the inferior vena cava, the pulmonary vein, and the ventricular cavity were catheterized. The results obtained are shown in Table III:

TABLE III

	Pressure	Oscillation	Oxygen
Pulmonary artery	6.0 cm.	1 cm.	15.5
Pulmonary vein...	3.0 cm.	...	25.8
Ventricle.....	61.0 cm.	2 cm.	20.7
Right auricle....	2.5 cm.	...	15.7
Superior vena cava (left) ..	1.5 cm.	...	15.4

But one question remains—that being the route traversed by the catheter in reaching the pulmonary vein, since technically the pulmonary vein was entered while searching for the aorta along the left cardiac silhouette. It appeared that the catheter passed in a retrograde direction through the mitral valve. The fact that the blood from the right atrium is of identical value with venous blood further supports the opinion that the catheter could not have traversed an interauricular septal defect.

Diagnosis—Cor triloculare biatrium. It is of interest in this patient that the futility of surgery would appear established.

DISCUSSION

It has been established that cardiac catheterization is a useful method of aiding in the localization of congenital heart defects. The procedure is not one attended by risk of complication or sequelae. It is particularly useful

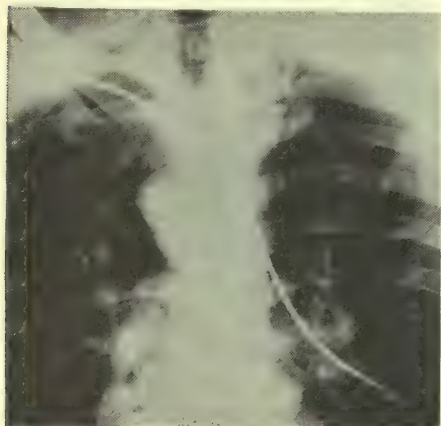


Fig. 4. — Catheter passing directly from superior vena cava into a pulmonary or bronchial vein.

where a definitive diagnosis must be reached as soon as possible. In 7 of our first 20 cases, it was possible to establish that an unusual silhouette did not represent the presence of congenital abnormality of the heart. In several others it was possible to determine the presence of more than one co-existing abnormality. This is of great practical importance, since in Case 1 the surgeon was warned that a large left superior vena cava would be encountered. This was found lying across the ductus arteriosus and associated with other venous abnormalities at the operative site. In our opinion, however, it is not possible to estimate with accuracy the size of the ductus that will be encountered by pressure or blood oxygen determinations. A patient with persistent ductus arteriosus, ligated in the same week as Case 1, showed only 1.4 volumes % increase in the pulmonary artery blood oxygen, as compared with the right ventricle and an enormous increase in the pulmonary artery pressure, which measured 117 cm. of saline. In this case the ductus again was found to be of almost the same diameter as the aorta. We offer no explanation for this discrepancy.

It is worth noting that the Bohn test has been of no assistance to us in the diagnosis of patency of the ductus arteriosus. We believe that the blood oxygen taken from the peripheral pulmonary artery circulation is identical with that in the main pulmonary artery in the presence of a ductus arteriosus. We further believe that this represents evidence to indicate the severity of the alteration in pulmonary circulation which results from the presence of a ductus arteriosus that is patent. We have not yet demonstrated a reversal toward the normal in this mechanism following obliteration of the ductus but this we intend to do.

Surgical selection can be based upon the information derived from cardiac catheterization. Cases 2 and 3 are examples of congenital heart lesions in whom the results of catheterization indicated that surgical procedures

presently known would not benefit these patients.

CONCLUSION

Twenty patients, in whom the presence of congenital cardiac abnormalities were suspected, were subjected to cardiac catheterization. The unusual frequency of persistence of the left superior vena cava was noted. It occurred in 3 of the first 20 patients. Where discovered, it was invariably associated with other congenital defects. The usefulness of this procedure in demonstrating unsuspected abnormalities and in selecting patients who might be benefitted by surgery is clearly borne out. The blood oxygen determination by the method of Roughton and Scholander has been found satisfactory in our hands.

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In the Good Old Days

(*The Canadian Nurse*, July 1910)

"Our profession stands, or ought to stand, for the highest and the best, and it is the sacred duty of every woman on graduating to pledge herself to do her duty conscientiously and to the best of her ability and at all times to uphold the dignity and honor of her profession. Now, it hardly seems to me as if a nurse were upholding the honor of her profession when, without adequate reason, she declines to respond to the call of duty, as, for instance, refusing to accept night calls . . . or by declaring that she would not accept a call between certain hours and in certain localities. These instances have occurred, I am sorry to say, and the nurses to whom I allude are not the older graduates, worn out from having given many years of good work to their profession, but young nurses—the products of the latest and most advanced training."

* * *

"Possibly the trouble with young nurses is . . . that the spirit of the age seems to be creeping a little into the profession—'Get as much as you can and give as little as you can.' If we can bring into our minds the fact that

we are training future nurses, we may be able to inculcate some principles into them so that in the next generation or two nurses will have a clearer idea of their obligation to the public, to their hospital, and to the profession."

* * *

In 1910, there were 1,600 copies of *The Canadian Nurse* being printed each month with a paid-up subscription list of 1,200. In 1950, forty years later, there are approximately 11,000 copies of the *Journal* printed each month, with a list of some 10,800 subscribers.

* * *

"There was a niece of a friend of mine who goes to the church school here. She passes the hospital daily and is very much interested in it. She keeps talking to her governess of what she is going to do: she is going to be a nurse. The governess, anxious to make the most of an opportunity, said, 'You must be a very good little girl and study hard to be a nurse.' The little girl pondered and said, 'Oh, do nurses have to study? Well, I think I'll just be an ordinary mother then.'"

Aux Infirmières Canadiennes-Françaises

Les Aides dans l'Equipe en Nursing

ANNE HAHN LINDBLAD et MILDRED STRUVE

Average reading time — 14 min. 24 sec.

CET ARTICLE n'est pas publié dans le but de discuter les avantages ou les difficultés que peut présenter le service des non-professionnelles ou aides-infirmières dans un hôpital. Le comité d'enquête de la National League of Nursing Education, dans un article "Study of Nursing Service," a déjà résumé les principaux problèmes qui découlent de l'organisation de ce système dans les hôpitaux américains.

Nous essaierons de décrire ici l'organisation d'un programme qui, après avoir été mis à l'essai durant une période de deux ans dans certains départements, et quelques mois dans d'autres, semble donner un résultat satisfaisant.

Le point culminant de ce système est de dégager les infirmières graduées et étudiantes de la responsabilité des soins d'ordre matériel et purement technique, afin qu'elles puissent concentrer leur énergie vers un travail plus scientifique, assurer plus de confort au malade, en même temps lui donner plus de connaissance de l'hygiène préventive.

L'hôpital, dont il est ici question, est un hôpital d'une capacité de 1,000 lits, reparté en salles, chambres semi-privées et privées. Organisé en service spécialisé de médecine, chirurgie, pédiatrie, obstétrique, psy-

chiatric, urologie, gynécologie, ophtalmologie, cet hôpital dispose encore d'un service de dispensaires. Bien qu'on y emploie des aides ou filles de salles depuis une vingtaine d'années, jamais elles n'ont contribué au service immédiat des patients, comme nous le voyons aujourd'hui. Leur rôle était limité aux travaux suivants: Faire les lits (fermés et ouverts), mettre de l'ordre dans les effets personnels des malades, porter les plateaux, ranger le linge dans les armoires, conduire les patients aux cliniques, etc.; la plupart de ces travaux, que l'on aurait dû faire exécuter par des servantes, étaient très fréquemment confiés aux étudiantes. Les aides n'avaient pas de qualifications spéciales; leur salaire était minime et on ne leur donnait aucun enseignement, ni aucune formation. Il appartenait à la garde en chef du département de leur assigner leur part de travail.

Les services que les bénévoles de la Croix-Rouge rendirent pendant la guerre démontrèrent que ces jeunes filles, en travaillant sous la surveillance immédiate de graduées, accomplissaient un travail très appréciable.

De plus, il a été également prouvé que cette catégorie de jeunes filles, malgré leur excellente instruction et leur personnalité distinguée, requéraient un entraînement et une surveillance adéquate.

PROJET D'UN PROGRAMME

A la lumière de ces faits, un comité fut formé parmi le personnel du nursing afin d'étudier la situation, d'apporter des suggestions, et d'établir un programme d'entraînement des

La traduction de ce volumineux article, publié en premier lieu dans *American Journal of Nursing* (jan. 1949), a été faite bénévolement par l'Hôtel-Dieu de Montréal.

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aides non-professionnelles. Ces employées devaient remplir autant que possible les tâches des aides bénévoles de la Croix-Rouge et améliorer ainsi la qualité du service des malades d'une façon notable.

Pour réaliser notre projet, nous avons choisi un petit département dont le personnel est composé d'infirmières graduées où le genre de service est régulier et le service n'est interrompu que pour donner aux aides l'enseignement de groupe. Nous avons également décidé que cet enseignement serait une activité départementale—i.e., propre à chaque milieu, de sorte qu'une aide formée au travail d'un département ne serait pas transférée dans un autre.

Toutes les activités furent déterminées et classées en trois catégories:

1. Les activités en rapport avec le soin du malade et accomplies par des filles de salles non entraînées, des aides de salles ou infirmiers.

2. Les activités non professionnelles accomplies par les servantes et commissionnaires entraînés.

3. Les activités accomplies par les infirmières seulement, soit étudiantes, soit graduées.

Une fois ces fonctions bien définies, il parut évident qu'on obtiendrait un meilleur rendement en éliminant le groupe d'aspirantes et en lui substituant des employées mieux qualifiées, qui auraient suivi un programme organisé et surveillé.

La plupart des travaux accomplis par les aspirantes furent assignés à des servantes et commissionnaires. Après quoi, on fit une nouvelle énumération des soins en rapport avec le malade, notant que le plus grand nombre de ces traitements étaient donnés par des infirmières. De cette liste, nous avons jugé quelle part de travail pourrait être remplie par les employées non-professionnelles, bien que qualifiées, travaillant sous la surveillance directe d'infirmières professionnelles, tout en tenant compte de la sécurité et du bien-être du patient.

Les conditions essentielles du succès dans la réalisation de ce projet furent:

1. De déterminer les aptitudes, de

reconnaître le statut et le titre officiel qui devaient distinguer les aides.

2. D'établir une échelle de salaires.

3. De choisir un uniforme attrayant et convenable—de disposer d'un vestiaire pourvu de toutes les commodités requises.

Un autre facteur de succès fut d'organiser un programme d'enseignement dans lequel a été confiée une part de direction et de surveillance aux infirmières professionnelles. Faire accepter ce plan aux infirmières et obtenir leur collaboration étaient aussi d'une importance primordiale. De plus, il fallait considérer un moyen pour développer chez les aides une mentalité—i.e., leur faire comprendre l'importance de leur coopération dans l'équipe du nursing, le sens de la responsabilité et de l'honneur qu'elles devaient apporter dans l'exercice de leurs devoirs.

Dès que tous ces plans d'essai furent tracés, des conférences individuelles et de groupe furent tenues avec le conseil administratif de l'hôpital, les chefs médicaux, et les membres du personnel.

Les raisons de ces conférences étaient d'expliquer le but à poursuivre et les résultats désirés, de mettre en lumière les divers aspects du programme, de considérer les suggestions, et de soumettre les résolutions à l'approbation de la direction. Ces conférences ont aidé à obtenir l'appui des groupes. Le fait d'avoir discuté nos plans en détail avant même de les avoir rédigés, nous donna l'impression d'avoir gagné la confiance et la collaboration de tous et de chacun.

CONDITIONS D'ADMISSION

Voici les conditions que l'on a établies à titre d'essai:

Qualifications et choix des aspirantes—

1. *Degré d'instruction:* Diplôme d'une école supérieure.

2. *Age requis:* 18 à 30 ans.

3. *Statut social:* Célibataire de préférence, quoique des femmes mariées sans enfants pouvaient être acceptées.

4. *Nationalité:* Aucune distinction.

CONDITIONS D'ENGAGEMENT

1. *Salaires:* Tarif à l'heure, assez élevé

pour attirer les candidates, avec promesse d'augmentation à des intervalles réguliers si le service est satisfaisant. Le salaire doit couvrir la première journée d'entraînement.

2. *Vacance*: Une rémunération en maladie et congé.

3. *Heure*: Une semaine de 48 heures avec une journée complète de congé.

4. *Un examen médical*: Préliminaire et soins médicaux gratuits.

5. *Uniforme*: Un uniforme gris, attrayant, en une pièce, avec poignets et collets blancs, bas beige et souliers foncés, noirs, blancs ou bruns, permettant de distinguer les aides infirmières des autres employées.

ORIENTATION

Une conférence préliminaire, traitant de l'application des règlements du personnel et des conditions d'engagement, est donnée aux candidates.

A cette conférence, l'infirmière en chef explique également les activités du service, ce que signifie être membre du personnel d'un hôpital, les responsabilités et la satisfaction que l'on éprouve au service des patients, les avantages d'un service de santé pour le personnel, la nécessité de se conformer à la discipline de la bonne tenue, du port de l'uniforme; enfin le programme d'entraînement, d'enseignement, et de surveillance. Ensuite, la candidate remplit des formules d'application; on fixe l'heure de l'examen médical et de la photo d'identification; et là encore on trouve l'occasion de donner de plus amples informations.

EXPÉRIENCE ET ENSEIGNEMENT

Vu que les aides doivent recevoir leur entraînement dans le département où elles sont en service, il convient, dès le début, de les assigner à leur département respectif. On ne peut assez démontrer l'importance d'un programme d'entraînement bien rédigé, d'un choix d'institutrices qualifiées, ayant une grande compréhension des principes sur lesquels repose l'organisation de ce programme et du but à atteindre, comme des moyens à prendre pour obtenir une surveillance suffisante.

Les institutrices de la technique du soin des malades, les institutrices de l'enseignement clinique et les surveillantes de ce service ont été démisées de leurs fonctions antérieures afin de se consacrer à plein temps à l'enseignement et à la surveillance des aides.

Ces institutrices firent connaître le programme au personnel infirmier des salles et leur donna des directives sur la répartition du service du nursing, afin que le travail fait par les aides puisse être des plus pratique. Nous avons appuyé fortement sur la nécessité d'une surveillance constante de tous les groupes d'infirmières travaillant avec ces aides.

Après une période d'essai, les résultats furent évalués. Se basant sur l'expérience acquise, des projets furent étudiés pour élaborer le programme des aides, afin de rendre leur service plus actif. Ce programme comprend des soins spéciaux en même temps que l'organisation du service du nursing avec des infirmières graduées et étudiantes, ces dernières en service de rotation.

L'emploi des filles de salles non formées fut discontinué. Quelques-unes, ayant fait preuve d'aptitudes et de qualifications, furent promues à la classe d'aides pour y suivre le programme au complet. Les autres eurent l'opportunité d'entrer dans la catégorie des servantes de divers départements, selon l'entente bien définie que, d'après l'élaboration du programme des aides, le groupe des filles de salles serait éliminé.

Heureusement, dans la plupart des cas, ces jeunes filles furent placées à la satisfaction générale.

LE TRAVAIL D'EQUIPE

Il est important que tout le personnel infirmier comprenne très bien la place des aides dans l'équipe du nursing — i.e., le rôle d'une infirmière professionnelle, graduée ou étudiante, et celui d'une aide.

L'infirmière en chef du département est la seule responsable des fonctions des aides infirmières lorsque celles-ci ont complété leur période de formation. La part de surveillance que l'infirmière en chef délègue à une in-

firmière en service avec une aide varie selon l'expérience de chacune dans le travail d'équipe et le genre de patients qu'elles ont à soigner ensemble.

Dans plusieurs occasions, nous avons eu des preuves qu'il était avantageux de placer dans les mêmes services des grands malades et des convalescents; dans ce cas, l'infirmière confiait aux aides le soins général des convalescents; elle tenait compte avec ces dernières, des besoins particuliers de chacun, se réservant les traitements et médicaments de tout le groupe ainsi que le soin des grands malades. En d'autres circonstances, l'infirmière et l'aide étaient assignées aux mêmes malades, travaillant ensemble auprès du même patient, donnant les soins avec beaucoup plus de rapidité et moins d'efforts pour le patient.

Quoique la répartition des soins particuliers des patients soit faite dans tous les départements de l'hôpital, il fut démontré que les aides donnaient un meilleur rendement lorsqu'elles exécutaient certains travaux de routine tels que: mesurer et inscrire le dosage des ingestas, préparer les repas des patients, servir les plateaux, prendre la température.

Que l'aide travaille directement avec une infirmière ou qu'elle accomplisse certaines tâches de routine, elle doit toujours recevoir des instructions précises sous la direction et surveillance constante de l'infirmière. Les étudiantes les plus avancées de même que les graduées ont été choisies pour faire partie du personnel de l'équipe du nursing. Elles doivent apprendre à se servir des aides non-professionnelles, et une fois graduées, capables de répartir les soins des patients avec une entière compréhension de leurs propres responsabilités.

NOMBRE D'AIDES EN RAPPORT AVEC CELUI DES INFIRMIÈRES

Le nombre d'aides requis pour donner un service satisfaisant dans

un département varie. Comme notre personnel diplômé n'a pas été régulier, il nous a été impossible de faire des études adéquates sur le nombre d'aides en rapport avec celui des infirmières. Toutefois, nous avons une idée du chiffre approximatif. Dans un département très actif, nous avons constaté que l'infirmière pouvait diriger plus qu'une aide. Là, où il y a un plus grand nombre de convalescents ou patients chroniques, la situation serait sans doute modifiée.

Dans un service de médecine de 28 lits, cinq aides infirmières dont deux en service de jour, une durant la soirée, une en service de nuit, et une autre pour suppléer aux aides en congé, semblent un nombre suffisant dans les salles des hommes; dans les salles des femmes, on exige une aide de plus en service de jour. Notons que les salles des hommes ont un service d'infirmiers de 24 heures continues.

En se basant sur un principe semblable, signalons que l'organisation d'un service de nursing, pour qu'elle soit satisfaisante tant au point de vue du malade que des aides, doit prévoir une rotation régulière du service de jour, du soir, et de la nuit, avec les cédules affichées à l'avance.

Ce plan de rotation est expliqué aux candidates en même temps que les conditions d'engagement. On affiche également le temps alloué pour les congés et les journées libres régulières. Le temps supplémentaire que l'on consacre à préparer ces cédules est largement dédommagé par la satisfaction qu'en éprouve les aides. En diverses occasions le personnel infirmier en chef convoque les aides afin de permettre à ces dernières de discuter leurs problèmes, d'exposer leurs griefs, et de donner leurs suggestions. De ces assemblées de groupe résultent des relations amicales entre les dirigeantes et les aides et une meilleure compréhension des responsabilités du service des malades.

(Le suite au prochain numéro)

Health is indeed a precious thing, to recover and preserve which we undergo any misery, drink bitter potions, freely give our goods.—ROBERT BURTON

Institutional Nursing

Auxiliary Workers in Hospitals

HELEN M. KING

Average reading time—11 min. 12 sec.

THE FACT THAT the subject of auxiliary personnel on the wards appears in nursing and hospital magazines so often and is a topic of discussion at many conventions points to two facts. First, auxiliary nursing personnel is now a recognized part of the medical team. Second, hospitals and the nursing world are not entirely satisfied with the contribution to, or the preparation for, the work of the average nurse aide.

At a staff conference of supervisors and head nurses the shortage of staff was being discussed. One head nurse said, "I find nurse aides very helpful—the patients like them. If you assign them their duties and keep them happy, they are of great assistance on the ward." She had grasped the important points in the utilization of nurse aides—that patients like them; that nurse aides need and must have direction; that their contribution to nursing must be accepted and appreciated to make them happy and contented; and that what they can accomplish is invaluable on a busy ward. A few years ago the average head nurse resented the nurse aide. Her usual comment was that she was not much help. Now, if she has an experienced aide on her ward, she does not care to part with her. This is a significant change of attitude forced on us by the shortage of nurses.

The increased demand for hospitalization requires far more professional nurses than are now available for institutional nursing. Hospitals are not in a financial position to employ sufficient graduate nurses

for all the routine bedside care, even if they were available. From an economic viewpoint, it seems ridiculous to use expensively trained people to carry out purely routine tasks which less skilled people can, under supervision, perform very satisfactorily. Miss Lucile Petry, chief of the Division of Nursing, U.S. Public Health Service, has said:

I think I am typical of many professional nurses who, first, with resistance and reluctance and then with regret, came to understand that professional nurses could not do everything for the patient . . . We know that we want expert care for patients . . . and so, even as we divide activities, we plan for co-ordination of activities into a unity of total care.

The administrative body of a hospital is concerned with providing safe and satisfying care of the sick. The average patient is not concerned with the up-to-date equipment the hospital provides but with the personal attention he receives. He wants his call-light answered promptly and his requests fulfilled. Most complaints which come to the supervisor's office relate to minor matters—call-bells not answered promptly; linen not changed; delay with commodities required—all services which do not require a high degree of training to perform. In a survey made in a hospital in the United States, it was found that 90 per cent of a patient's calls could be answered by ward personnel other than the professional nurse. These many personal services contribute much to the comfort and peace of mind of the patient. Patients have accepted the nurse aide very well and speak well of her, yet in times of

Miss King is assistant director of nursing service at the Vancouver General Hospital.

distress and anxiety it is still the graduate nurse they ask to see. In any emergency, it is recognized that the professional nurse is essential.

The fluctuating demands of a general hospital make it very difficult to estimate ahead of time what staff one will require. When a peak load is suddenly encountered, it adds to the confusion if a number of new nurse aides have to be added to the staff, all of whom have varying backgrounds of experience and training and who know nothing of the routine of the wards. Moreover, when one requires nurse aides in a hurry, the labor market seems completely empty of suitable people. The solution is in the operation of a school where nurse aide students all receive a prescribed training and from which a hospital can employ reliable workers. Repeated turnover of any type of staff is a very expensive operation and the time and work it involves is something which cannot be ignored.

An experiment was tried, with the cooperation of our teaching department, to train nurse aides speedily for summer vacation relief. The rapidity with which these girls became of value was most satisfying, both to the teachers and the wards. They were taught the theory and given the practical demonstrations in the classroom in small groups. Then they were taken to the wards and allowed to carry out the procedures in actual situations under supervision. They were assimilated rapidly as members of staff and were of real assistance from the first day. This is on-the-job training which has great value.

Schools for nurses aides have been in operation for some time on this continent. One such school has been operated for three years in Vancouver. The candidates received three months' theory and practice in the school followed by eight months' experience in various types of nursing in the different hospitals. There was difficulty in arranging with the hospitals for the necessary ward experience, since budgets had to be adjusted to meet the salaries of these students who were paid on a different basis from the

regular nurse aides. In addition, the number of students fluctuated and the hospitals could not always rely on a uniform number at each rotation. The coordinating supervisor for the practical experience from the school is forced to divide her time between several different hospitals, so the follow-up work is difficult. The student had to make an adjustment first of all from the quiet environment of the school to the busy atmosphere of a hospital where she was unknown and strange, followed by further adjustment to the different hospitals to which she was sent. As every gardener knows, transplanting a seedling always delays growth for a short time. Nevertheless, the reports on these students have been good. They have taken their work seriously and proved reliable. The older ones found the hospital work tiring but would probably do excellent work in a home.

The salary of the qualified nurse aide is approximately 75 per cent that of the graduate nurse. Many graduate nurses do not feel that the nurse aide carries 75 per cent of the nursing load. The graduate admits that the nurse aide is a valuable assistant but feels that her scope is limited. It is true that she has not had much teaching and training. Perhaps the biggest problem is that the graduate nurse is still learning how to assign work, supervise and teach instead of struggling to do so much herself.

The supervision of auxiliary workers and instruction on the job may have to be added to the curriculum of the student nurse since, if the nurse aide is recognized as a permanent member of the hospital staff, she has to be used to advantage by the nurse in charge, who in turn must understand how to assign duties to her. Inconsiderate and tactless handling causes friction, rapid turnover of staff, and insecurity to the worker in question. Poor instruction and supervision lead to mistakes which in turn lead to fault-finding. This is followed by a feeling of insecurity and resentment on the part of the nurse aide. Time must be spent in proper teaching,

repeated demonstrations, and good follow-up on the ward, in order to gain good dividends in nurse aide service. Nurse aides can be encouraged to carry more and more of the nursing load as long as there is adequate supervision and better teaching.

The task of selecting candidates for nurse aide duties is not without its difficulties. The most promising may prove disappointing, the most unlikely valuable. A pleasant personality and good appearance are essential. The girl should be strong and healthy as far as it is possible to judge. She is more likely to stay on staff if free from domestic responsibility. Changing shifts causes difficulty, especially where there are children at home, so that the married woman is somewhat of a risk. One needs a person with a genuine interest in nursing and not a girl merely looking for a job and a pay cheque.

The selection of a suitable uniform for this group is important. It must add to their dignity and prestige and inspire a certain amount of confidence, yet it must be distinct from that worn by students and graduates. There is a tendency for nurse aides sometimes to pretend to be nurses and they can be quite convincing on occasions. We have found the handkerchief cap both becoming and distinctive, while the word "Aide" in large red letters on the white uniform leaves little doubt as to their status.

The teaching program for nurse aides must be taken seriously with nothing haphazard about it. The selection of their instructor is an important matter. She must be enthusiastic for her group, an excellent teacher, kindly yet strict, professional and able, by her example, to portray a good approach in dealing with people.

There are other workers on a hospital ward who must cooperate to give a unity of total care. These are the orderly, the ward clerk, and the ward assistant or maid.

The orderly is a very essential member of the nursing team. Yet, in the average hospital, insufficient attention is given to his preparation or

to his efficient contribution to the welfare and comfort of the patients. A good orderly is a tremendous help—a poor one is a positive menace. His position is not altogether satisfactory from anybody's point of view, least of all from his own. He works under the direction of the head nurse but she is not, in all instances, responsible for his work. He has little prospect of advancement or of self-improvement in his job. His daily routine usually holds very little of real interest.

The work of the orderly is comparable with that of the nurse aide. We agree that the nurse aide should have adequate instruction plus good supervision in order to ensure good care of the patient. In the armed forces the sick bay attendants and nursing orderlies were given a certain amount of instruction and responsibility with regard to the nursing. Probably all orderlies would have greater satisfaction in their work if they were more closely identified with the total care of the patient and were used on a male ward in the same way that the nurse aide is used on a female ward. It might be practicable to staff some male wards with trained male attendants, with a graduate nurse in charge. Schools of nursing might well adapt programs for the training of male nurses who, after being duly registered, would be capable of taking charge on such a ward. This arrangement would iron out some of the friction which exists and might be the answer to procuring good orderly service.

The ward clerk is an accepted auxiliary worker in many American hospitals and is gradually appearing in Canada. Present-day ward administration is encumbered with an accumulation of detail. Head nurses spend valuable time copying timetables, requisitioning supplies, writing up reports on charts, answering the telephone, and directing traffic generally. Some of this requires professional knowledge but much of it does not. The head nurse could be relieved of much of this routine work by the ward clerk.

Finding the suitable person for this position is the problem. She must be accurate, reliable, and efficient, yet not officious. She must have initiative but not overstep her limitations. An older person probably is preferable, since she is more likely to stay in her job. It is difficult to instal a ward clerk if the hospital is old and not designed for present-day demands. To be of real value, she should serve a large unit with her desk, separate from the nurses' station, in a prominent position where doctors and visitors pass. She needs her own telephone and equipment.

As in the case of nurse aides, to pay dividends in terms of good performance, time must be spent in initiating the ward clerk into her duties. The whole situation can be most confusing to a person unused to hospital life and, unless well taught, she wastes her own time and that of the nurses as well. She must have a firm grasp of all the detail before she is left on her own; otherwise she becomes discouraged and resigns.

Ward assistants are a group who come between the nursing and the housekeeping departments. They are

chiefly concerned with non-nursing duties, yet come in contact with the patients. Twenty years ago the student nurse carried out all the duties of the ward assistant in addition to nursing the patients. She dusted, cleaned equipment, arranged flowers, carried trays, and ran messages. The ward assistant was added when we realized what valuable nursing hours were being wasted. Now we have the nurse aide to carry out semi-skilled nursing duties as well. The combined work of all these workers is necessary for the smooth running of a unit. It might be wiser to combine all nursing duties and all housekeeping duties under their respective departments to prevent overlapping. The nurse aide can supplant the ward assistant and combine many of her duties. Where too many groups are responsible, we do not have efficiency or serenity.

In reviewing the whole picture of the auxiliary worker in the hospital, good care of the patient will result if there is good coordination. Teaching, supervision, and direction are all required to bring to the bedside thoughtful, kindly nursing service.

The Battle Against Leprosy

(Continued from page 547)

an excellent reputation and has achieved remarkable results with the new drugs. A number of patients were discharged as cured; others are making rapid progress towards recovery; complications leading to blindness and deformities are becoming less and less frequent. Preventive measures, including medical examination of school children and treatment of the disease in its early stages, have proved extremely effective. Of 100,000 children examined, 220 were found to be suffering from the disease.

Considerable sums of money are provided by the Colonial Development and Welfare Fund of the British Colonial Office to further the anti-leprosy campaign. But it is on the British Empire Leprosy Relief Association (B.E.L.R.A.) in London, a welfare organization maintained by voluntary contributions,

that dozens of large and small hospitals and clinics chiefly depend for the training of doctors, nurses, and other workers. Representatives of this organization go overseas in an advisory capacity, giving expert advice on the spot; medical supplies of all kinds are made available; and contact is made with other organizations and with individuals in the British Commonwealth willing to assist in the good work. In cooperation with the British chemical industry, experiments are being regularly carried out with new drugs and this research has recently led to the discovery of a specific drug of unexampled efficacy. It is confidently expected that this new drug, as yet unnamed, will do much to halt the ravages of the disease and that it will, in fact, mark the turning-point in the battle against leprosy.

Nursing Profiles

Madeline S. Taylor is director of provincial organization for Quebec for the Canadian Cancer Society. Graduated from the Montreal General Hospital in 1924, Miss Taylor engaged in private nursing for a year and a half before joining the staff of the Montreal branch of the Victorian Order of Nurses. She was recipient of the Mildred Forbes Scholarship, awarded by the M.G.H. in 1928. After receiving her public health certificate from the McGill School for Graduate Nurses, Miss Taylor went to Saskatchewan where she was instrumental in organizing a new V.O.N. branch in Regina. In 1931 she returned to the Montreal branch where she acted as supervisor—first of Rosemount district and later of the North End district. She resigned in 1940 to enlist with No. 14 Canadian General Hospital, R.C.A.M.C.

After six months at Camp Borden, Miss Taylor went overseas with her unit. In 1943 she left England for service in the Italian Campaign and was on a ship that was torpedoed en route. While in Italy she was acting matron of No. 11 British General Hospital for a time. Returning to England in 1944, Miss Taylor was the first Canadian nurse to be discharged from the R.C.A.M.C. to join UNRRA. She proceeded to Germany as a team nurse. Six months later she was

made a supervisor and when the work was reorganized she became the chief nurse with UNRRA in the American Zone of Germany.

Miss Taylor was matron of the displaced persons reception centre at St. Paul l'Ermite, Quebec, for some time after her return from Europe. She was recently elected president of the Montreal Unit of the Nursing Sisters' Association of Canada.



FLORENCE QUIGLEY

Florence Phyllis Frances Quigley is an associate professor of nursing education at the University of Western Ontario School of Nursing. Born and educated in London, Ont., Miss Quigley entered the school of nursing at Victoria Hospital, London, with her B.A. degree. Since graduating in 1929, she has added two more degrees to her qualifications—B.Sc. in nursing from U.W.O. and M.A. from Columbia University, New York.

Miss Quigley's first position was as instructor at the Public General Hospital in Chatham, Ont. A year later she transferred to her alma mater where she was in the teaching department until 1943. After a year in private nursing, Miss Quigley was appointed director of Home Nursing, First Aid and Emergency Nursing Reserve with the London branch of the Canadian Red Cross Society. She was appointed to her present position in 1949.

Keenly interested in community activities, Miss Quigley is active in many organizations



Max Gragge

MADELINE TAYLOR

beside nursing, including the Y.W.C.A. and church groups. For relaxation, she turns to such pursuits as drama, opera, reading, and knitting. She is fond of travel, also.

Berthe Bourbonnais is now the educational director with the Metropolitan Life Insurance Company nursing service in Montreal. Born in Coteau du Lac, Miss Bourbonnais was educated in Montreal and graduated from Hotel-Dieu there in 1923. She joined the M.L.I.C. nursing service in 1926 after three years of private nursing. Her first appointment was with the Sherbrooke branch. She received a company scholarship in 1928 and enrolled in the public health nursing course at the University of Montreal. Her next five years were spent at Rivière du Loup, then back to the Montreal branch until she was appointed head nurse at Quebec in 1937. She returned to Montreal in 1944 and has moved ahead steadily from head nurse to supervisor to her present position. Miss Bourbonnais has enriched her professional preparation through a post-graduate course in nursing education at Simmons College, Boston, and through an observation tour arranged by the M.L.I.C., both on scholarships.

Miss Bourbonnais has taken an active part in association activities. She is secretary of the French chapter of District 11, A.N.P.Q., and a member of the Comité des Ecoles. She enjoys reading and travelling, loves to cook and to make her own clothes. Her latest accomplishment is learning to play canasta.

Ruth Gaw assumed her duties as director of nursing at the Guelph General Hospital in June. She graduated from the Hospital for Sick Children, Toronto, in 1931. After a brief period as assistant head nurse there, Miss Gaw engaged in private nursing for five years.



LaRose, Montreal

BERTHE BOURBONNAIS

She was in charge of the operating room at Anson General Hospital, Iroquois Falls, Ont., for two years prior to her enlistment with the R.C.A.M.C. Upon her return from overseas in 1945, Miss Gaw enrolled in the course in teaching and supervision at the McGill School for Graduate Nurses. She joined the teaching staff of the Homoeopathic Hospital, Montreal, in 1946, becoming assistant to the director of nursing the following year.

Isabel Lowrie has retired as matron of the Municipal Hospital, Claresholm, Alta., after 20 years of active, happy service. Holding the unique record of being the first girl from Claresholm to go into training as a nurse, she graduated from the Calgary General Hospital. Much feted at the time of her retirement, Miss Lowrie had the joy and satisfaction of seeing the new wing of the hospital officially opened before she left. She will continue to reside in Claresholm.

In Memoriam

Louise Flanagan, R.R.C., a Welsh nurse who saw active service during World War I and who engaged in hospital duty in Vancouver some 30 years ago, died there on May 2, 1950, at the age of 82.

Madaline (Duncan) Gordon died in Batavia on March 28, 1950, following a long illness.

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Elizabeth J. Kenny, who had practised



Ashley & Crippen, Toronto
AGNES C. NEILL

her profession in Toronto for some years, died there on May 6, 1950.

* * *

Winnifred E. (Forbes) Monroe, who graduated from Clifton Springs Hospital and who for a number of years was on the staff of Wellesley Hospital, Toronto, died in Ottawa on April 30, 1950, after a short illness, at the age of 64. During World War I Mrs. Monroe served in England and France.

* * *

Nora B. Montgomery, who graduated from the Woodstock General Hospital, Ont., in 1915, died in Woodstock on May 10, 1950, after a long illness. Miss Montgomery was overseas with the C.A.M.C. during World War I and, afterward, was on the staff of the Westminster Hospital, London, Ont., for nine years before ill health caused her retirement.

* * *

Agnes C. Neill, O.B.E., R.R.C., LL.D.,

a graduate in 1925 of Toronto General Hospital, died suddenly in Peterborough, Ont., on May 5, 1950. From 1926 to 1935 Miss Neill was head nurse in the Private Patients' operating room. A year at Bedford College, London, Eng., preceded her appointment as surgical supervisor at T.G.H. In September, 1939, she resigned to enlist with the R.C.A.M.C. She went overseas as matron of No. 15 C.G.H. in 1940. Two years later she was appointed Matron-in-Chief overseas.

In 1945 she returned to Canada to become Matron-in-Chief of the R.C.A.M.C. Nursing Service in Ottawa with the rank of Lieutenant Colonel. She retired from active service in 1946. For a time she was an area nursing consultant with the Department of Veterans Affairs.

A vital, dependable, sympathetic personality, Miss Neill was a woman of many interests. She had taken an active part in the activities of various professional organizations and was well loved by all who knew her.

* * *

Mary Catherine Stewart, who graduated from the Toronto General Hospital in 1895, died suddenly in Toronto on April 28, 1950. Hospital positions were held in Chicago prior to World War I when she served overseas with the Q.A.I.M.N.S. and the C.A.M.C. She was superintendent of the Guelph General Hospital for many years.

* * *

Evelyn (Dawe) Ure, who graduated from the Vancouver General Hospital in 1924, died in Nelson, B.C., on May 4, 1950, at the age of 47. Mrs. Ure worked at the V.G.H., at Royal Columbian Hospital in New Westminster, and was a supervisor at Kootenay Lake General Hospital, Nelson, for a time.

* * *

Dorothy (Hoover) Wood, who graduated from the Mack Training School, St. Catharines General Hospital, in 1925, died on April 7, 1950.

The Eskimo

There is some confusion as to the exact origin of the word "eskimo" although it is generally conceded to have come from the North American Indians living to the south of the polar regions. It means "people who eat their food raw."

Anthropologists agree that the eskimos are one kind of North American Indian, both in blood and in language.

About 2,000 years ago the eskimos dwelt in the forests north of Lake Superior. For some reason they migrated northward until they reached the arctic coast of Canada. There they split into two main bands—one travelling northeast, the other southeast.

Gradually they spread out until today various eskimo bands are found throughout the north.

Lyle Creelman Writes . . .

Average reading time — 5 min. 36 sec.

We have just attended the opening of the Third World Health Assembly. From the gallery of the Assembly Hall in the Palais des Nations, Geneva, we watched the representatives of 61 nations as they took their places. Outstanding among them was Her Excellency Rajkumari Amrit Kaur, Minister of Health for India and leader of their delegation. She was dressed in a beautiful mauve silk sari which the women of India wear so gracefully. Later the Rajkumari was elected President of the Assembly—a singular honor and we were, of course, proud that it was accorded to a woman. Another colorfully dressed delegate was Mrs. Aung San of Burma. In the whole Assembly there are only three women delegates, the third being Mrs. Whitehurst, from the U.S.A., where she is very prominent as an organizer of voluntary work.

Each Member State is permitted three delegates and as many advisers as they wish to bring. Only two countries have sent a nursing adviser—the United Kingdom and the United States. I look forward to the possibility of Canadian nurses being represented by one of their own members at future World Health Assemblies. Mrs. Patterson, who has just received an appointment as Dean of the School of Nursing of the

University of Washington in Seattle, came from the United States, and Miss Udell, Chief Nursing Officer for the Colonial Service, from the United Kingdom. The International Council of Nurses is represented automatically as it is one of the non-governmental organizations which has official relationship with WHO.

Mr. Trygve Lie, Secretary-General of the United Nations, addressed the Assembly, and reminded us that the real challenge of the second half of the 20th century "is not expressed in the ideological and power conflicts that monopolize the headlines today. The supreme challenge is presented by that great majority of the population of the world—over 16 hundred million—whose poverty, hunger, and insecurity must be substantially remedied if they are not to result in new and disastrous upheavals. Most of these people live in the so-called under-developed areas of the world, mainly in Asia and Africa. They are moving rapidly toward political equality. They will no longer accept the grinding poverty that has been their fate for centuries. We cannot meet this challenge successfully at the snail's pace of today. We cannot meet it by half-way measures. We cannot postpone it until a more convenient time. The challenge is here and now. Bold and creative action on a world-



Conducting the meeting



wide scale is required in order to bring about real improvements in the living conditions of these 16 hundred million people—improvements that will begin to be evident within the next five years and will have as their goal the doubling of living standards within 20 years in many of the poorer areas of the world.” Mr. Lie thus presented a real challenge to us as members of one of the Specialized Agencies whose program is indispensable in attaining this goal.

The Secretary-General then laid the corner-stone of our new permanent Headquarters. As I write now the noise of the machinery is loud and continuous since the building is being erected just across the courtyard from our present offices. In the picture you will see, on the extreme left, Dr. Brock Chisholm, Director General of WHO, in the centre Her Excellency Rajkumari Amrit Kaur, and on her left, Mr. Trygve Lie.

Next week the Program Committee will discuss the report of the Expert Committee on Nursing which met for the first time last February. We think that they will approve the report,

after which it will be printed and available for all of you to read. I hope you will study it carefully and remember that the committee had to keep in mind the needs of all the countries of the world, including, for example, such geographically small areas as Liberia. Yesterday Dr. Togba, delegate from that country, told the Assembly something of their problems. They have two and a half million people and only 30 doctors! Outside of their capital city, Monrovia, they have no roads. Modern sanitation is non-existent. But here is the hopeful thing for nursing—in their one school they are insisting on high school graduation for entrance so that they can send some of their nurses abroad for post-graduate study. They will return to their own country to be the leaders in nursing. Their main task will be to help develop more schools for the preparation of the nursing personnel needed in such great numbers. Through setting such standards as this, Liberia is taking the wiser and the long-term view, which is so hard in the face of the many immediate needs.

I wanted to tell you about my first trip to Paris over last week-end. Paris is everything you have read about it, and just now—with the chestnut trees in bloom, the fountains playing, and the principal buildings illuminated—the city is a never-to-be-forgotten sight. I had the pleasure of driving around one evening with Dr. and Mrs. Rolf Struthers, formerly of Montreal, now with the Rockefeller Foundation in the European Office. Dr. Struthers had just returned from a two-month trip to Africa where he met many Canadians. We do get around! Luck-

ily for me I had a chance to drive from Paris to Geneva. All along the road through the Forest of Fontainebleau, young and old were selling great bunches of lily of the valley which they had picked in the woods. The countryside was at its best—fruit-trees in blossom and lilacs, white, mauve, and purple, in abundance. We had dinner in Dole—a centre for wine-growing and the home of Pasteur. This country is so full of beauty, history, and interest that I am sure it will never lose its fascination for those of us from a very young nation.

Annual Meeting in Alberta

The 32nd annual meeting of the Alberta Association of Registered Nurses was held in Edmonton April 13, 14 and 15, 1950, with 276 members registered.

Miss J. Clark, president, called the meeting to order at 9:45 a.m. Rev. A. McQueen, Robertson United Church, gave the invocation. His Worship the Mayor, Mr. Parsons, gave the address of welcome to all members. On behalf of the association Miss A. Hoyt, Lethbridge, replied to the address of welcome.

The institute held for the first day and a half studied the "Problems of the Aging Population." The advances of medical science have resulted in helping people to live longer thus creating new problems. Many things are being done to alleviate the ailments so closely linked with all ages. Speakers stressed the difficulties encountered in arranging domiciliary care, the importance of providing homes for the chronically ill, the necessity for adequate diet, exercise and occupation. Caution was advocated in the use of infra-red lamps with the aged.

The value of occupational and vocational therapy was recognized. Warning was given against aged persons undertaking leathercraft work which required good eyesight and coordination. Rug-hooking was suggested as more suitable activity. Employment in types of work where quality service is preferred to speed was advocated.

Lively discussion was a notable feature of the institute. It was the consensus that nurses in their own communities were in a position

to crusade for adjustments in the problems of the aged on a non-sentimental basis. A large number of experts discussed various aspects of the problem during the institute.

In her presidential report Miss Clark remarked that the past year was one of growth for the association. The active membership of 2,322 was the highest on record. For the first time the associate membership was made available to non-practising nurses and 891 members joined on this basis. She welcomed delegates from chapters and districts and hoped that during the next year more chapters would be organized. 1949 marked the first year of the increased fee and we were able to return to savings an amount equivalent to that borrowed to cover the operating deficits in 1948 and 1949.



JEAN S. CLARK—President

The registrar's report showed that chapter formation had been one of the most outstanding and gratifying projects of the year. The following important changes in policy were noted: Courtesy permits discontinued; change in policy regarding temporary permits; change in by-law regarding associate membership.

The progress of *News Letter* advertising was reported. To date we have had paid advertising in the approximate amount of \$900 and have prospects of more for future issues.

The treasurer referred to the auditor's statement for 1949 which indicated that receipts for the year amounted to \$20,288.36—of this amount membership fees totalled \$18,771.50. Expenditures amounted to \$16,872.54, leaving a surplus of \$3,415.82. On April 1, 1950, \$2,993.48 was invested in Ontario Hydro Electric Power shares.

Miss Shaw and Miss Chapman gave reports on *The Canadian Nurse* and submitted a resolution that the A.A.R.N. incorporate in the annual fee for active members the subscription fee of \$2.50 per year for *The Canadian Nurse*. We are happy to state that this resolution was unanimously endorsed.

Miss Helen Peters reported that 20 students had been benefitted by the Dominion-Provincial Grant—6 having received financial aid in the full amount of \$150 and 14 received \$75 each.

Miss Clark reported that the Health Survey Committee had been meeting monthly during the past year and hoped to present a final report by this fall. She expressed her sincere thanks for the cordial reception received on visits to all parts of the province. She further reported that the committee had met with all the Liaison Committees; the A.A.R.N. Liaison Committee met with the Survey Executive October 4 and with the entire Survey Committee on October 20 and recommendations submitted by the A.A.R.N. were reviewed at that time. Miss Clark reported that 10 Dominion Health Grants were again available to the province for the 1949-50 fiscal year in slightly higher amounts than the preceding year.

For the first time in our association, disability insurance has been under consideration. After studying many group plans, that of the North American Life and Casualty Co. was approved and presented to the general meeting and endorsed by a majority.

Miss M. Cogswell submitted the following resolution:

WHEREAS, In a democracy everyone should be able to plan for security in his old age; and

WHEREAS, There is no pension plan available for the majority of nurses in Alberta; therefore be it

Resolved, That the Alberta Association of Registered Nurses request the Associated Hospitals of Alberta to endorse a pension scheme for nurses employed in Alberta hospitals.

The report of the Legislation Committee proposed the following changes and additions to the A.A.R.N. Act and By-laws:

1. By-Law I (p. 6 of the Alberta Registered Nurses' Act) has been revised: *Associate (non-practising)*. Add (3) Associate members, failing to renew their membership on or before the first day of February each year, shall become inactive (non-practising) members.

2. Every active member, who has failed to pay the annual fee hereinafter provided by the 15th day of February in that year, shall be suspended as a member of the association.

Form D—Annual first notice of Active and Associate Membership Fees now reads "For active members, it is further provided . . . this association."

Form E—Annual 2nd notice of Active Membership Fees (deleting "and Associate").

Nursing Permits: (a) Annual temporary permits to be issued for not more than two years to applicants for reciprocal registration:

(i) Who do not meet the academic qualifications of the Alberta Registered Nurses' Act at the time at which they become registered elsewhere or (ii) who are now working under Temporary Permits during which time they will be required to make up their academic deficiencies or to write and pass the Grade XI Placement Examinations as administered by the Alberta Department of Education.

That these nurses who hold a Temporary Nursing Permit Statement be granted annual Temporary Permits for not more than two years during which time they must make up their deficiencies and become eligible for registration.

It was with a great deal of pleasure that we had the privilege of hearing from Miss Florence Martyn, a 1915 Royal Alexandra Hospital graduate, who has had a most color-



Council of A.A.R.N.: Seated—MAY DEANE-FREEMAN of Calgary; FRANCES MCQUARRIE of Edmonton; ELIZABETH BIETSCH of Edmonton; HELEN PENHALE, Director, University of Alberta School of Nursing; Standing—FRANCES FERGUSON of Calgary; SISTER ANNUNCIATA of Banff; JEAN BROWN of Calgary.

ful nursing career, both in America and India. Miss Martyn has been studying for her degree in public health in Washington, and is now on her way to Pakistan to assist in setting up a Department of Public Health in that country.

The Educational Policy Committee proposed the following resolutions which were endorsed by the general meeting:

(1) That the committee go on record as approving the principle of Evaluation and Accreditation as sponsored by the C.N.A.

(2) That the committee go on record as disapproving the organization of a Student Nurses' Association in Alberta at this time.

(3) That each school of nursing be circularized in regard to sending at least one student delegate to the C.N.A. biennial in Vancouver.

(4) The committee did not approve of providing official transcripts of nursing courses as it was felt that these might not be correctly interpreted by other registered nurses' associations.

At the Institutional Section meeting, the suggested personnel policy outline of the C.N.A. was read and discussed. The following resolutions were proposed and endorsed:

WHEREAS, In various hospitals employing nursing aides there appears to be an insufficient differential in salaries paid various grades of nursing personnel; and

WHEREAS, There is considerable variation in salaries paid to registered nurses in the different hospitals of Alberta; therefore be it

Resolved, That a committee be formed to study and formulate a provincial salary schedule for nurses.

This committee has now been appointed.

At the Public Health Section meeting, it was the consensus that financial recognition was not made for post-graduate and degree work in the Provincial Department of Health and it was proposed that this be brought to the attention of the department.

At the meeting for official delegates of districts and chapters reports were heard from six districts: Ponoka, Calgary, Medicine Hat, Red Deer, Edmonton, and Lethbridge. Reports were also received from the six chapters newly formed at Banff, Jasper Place, Peace River, Vegreville, Blairmore, and Grande Prairie. Discussion developed as to whether the financing of the chapters should be a district or provincial responsibility.

Miss Ferguson, Registration Consultant of Nursing Aides, reported many noteworthy

developments in nursing aide fields. The 40-week training program has been subdivided to provide for a 15-week period of instruction at the school, two periods of 10 weeks each at hospital training fields for nursing experience under supervision, with a period of 5 weeks for review and final examinations. Effective April, 1950, there are 344 certified nursing aides and 147 trainees.

At the Nursing Aides Advisory Council meeting in October, 1949, salary and uniform revisions were approved as follows: The recommended minimum salary schedule for aides in hospitals is now: 1st six months, \$100 gross; 2nd six months, \$110; 2nd year, \$115; 3rd year, \$120 per month gross. The recommended minimum schedule for aides engaged in private duty is \$4.50 per eight-hour day plus 50 cents an hour for overtime, and meals while on duty; for full-time home duty (a

normal working day) \$100 per month.

At the Private Duty Section meeting the financing of registries was discussed. At the present time the financial standing in all the districts is most encouraging. Some concern was expressed by the private duty nurses regarding the nursing aides wearing caps and pins. The A.A.R.N. has presented a recommendation to the Nursing Aide Council that their caps be a distinctive grey. It was pointed out that in some hospitals and doctors' offices nursing aides and non-certified auxiliary workers were being asked to assume responsibility for the things for which they are not prepared. It was proposed that a recommendation be sent to the College of Physicians and Surgeons and the A.H.A. protesting this matter.

CLARA VAN DUSEN
Registrar

I had a Dream

It seemed to me I stood
In a small garden, hedged and brimming over
With exquisite flowers—honeysuckle, clover,
Roses and harebells—lilies white and tall;
Flowers of spring and summer mixed and on
them all
The shade of guardian trees and radiant light;
Till, half aloud, I said, "This heavenly place!
Whose can it be?" Then, as I stooped to see
A half-hid flower, lo! I caught a sight
Amazing; little graves were crowded there,
So small I had not seen them—yet there were
Nothing of loss or sadness—just delight!

A little breeze stirred round me and I heard
An answering whisper—"This is all your own.
Here you have buried, like a deep-dropt seed,
Thoughts and desires you were ashamed to
own,
Sifted them as they rose to birth again;
The scornful word, the ungenerous deed,
The look, the laugh, that had a hint of pain.
So are the spirit forms of these most fair.
The Alchemy of Love changed them to flowers
To enrich your life and cheer your loneliest
hours."

I woke as I had slept, with wondering joy!
And now, whatever life to me may seem,
Love gives to me the comfort of my dream.

GRACE H. BAKER
Age: 83 years

Trends in Nursing

Average reading time — 10 min. 24 sec.

Canada Leads

"CANADA," to quote an article by Mr. H. L. Keenleyside in the *International Journal*, "is now, in relation to its population, one of the two or three most richly endowed countries of the world." Is that not something to make us pause and consider the Canadian people's responsibility for the common material problems facing humanity? The recognition of this necessity emphasizes also the need for an increased population in this country. The present population of Canada is inadequate for the most effective development of our natural inheritance.

Moreover, as the pressure of population on the means of subsistence elsewhere grows more onerous, there will be an increasing demand that Canada provide homes for many of those who are elsewhere dispossessed. In admitting immigrants from other parts of the world we are lessening the political dangers to which we are exposed by the magnitude of our riches; and at the same time we are building up within Canada a greater power of production that can be used to the advantage of ourselves and of humanity as a whole.

So long as any human beings, anywhere, need shelters; so long as anyone, anywhere, lacks fuel or clothing or food, so long will the demand for Canadian products and services persist. Our forests, our fields, our lakes and seas provide a vast store of renewable resources, and by proper husbandry they may be made a permanent reservoir on which we may draw to satisfy the elementary material needs of the men, women, and children of every land.

As the trustees of a great inheritance we have a responsibility as well as an opportunity. The responsibility is to the people of the world who urgently need the resources with which we have been so generously endowed. The opportunity is to meet this need and, in doing so, to profit ourselves and our country. Thus

we have been doubly favored and our obligation is proportionately increased. It was Christ Himself who said that "unto whomsoever much is given, of him shall be much required."

Economics—A Way of Life

In a forceful address, Dr. M. M. Coady, Director of Extension for St. Francis Xavier University, has declared that the most important consideration in any plan for solving present-day economic and social problems is the evolving of a scientific and democratic method through which to distribute created wealth.

Through centuries the people have struggled to free themselves from slavery and the ideal for which they fought was individual ownership and private initiative. This had eventually been obtained but, unfortunately, certain individuals and organized groups obtained control of wealth and resources which, though inherently belonging to the people as a whole, were used to institute and perpetuate a new type of economic slavery.

There is a movement in progress which is the real revolution—the process by which the people can enter business and, through their cooperative efforts, participate in the wealth which they create. It is the only solution which will save democracy, if the awful forces of bloody revolution now rampant will not engulf us before such orderly processes can become effective enough to stave off the cataclysm.—excerpt from *The Maritime Co-operator*

Whose, the Responsibility?

A spot study made in January, 1947, of 26 leading hospitals in Canada revealed that student nurses were carrying from 33 to 85 per cent of the service load to the detriment of their educational experience.

Surely this is factual evidence that

there is something wrong, not only with the method of educating students for nursing, but also with the method of providing nursing service in hospitals.

Educational programs to meet ever-increasing nursing service requirements demand an ever-increasing number of hours of lectures and demonstrations. Present hospital school practices include one or other of the following methods of procedure:

(a) *Class hours interspaced throughout nursing service periods*—a procedure frustrating to the student and unsatisfactory to the patient whose needs must be transferred to another nurse, with oftentimes an intervening period of non-attention; or (b) *a block system* which in many instances causes mental indigestion from the cramming process where correlation of practice and theory are impossible of achievement.

Thirty years ago, the age requirement of students was approximately 23, whereas now it is generally 18. Fundamentally, nursing has to deal with human beings during periods of fear, stress, and pain. It requires a deep understanding of human nature and behavior. The immaturity of the average student today, which is not a mere matter of chronological age, provides a situation where many personal as well as professional adjustments have to be made. We take many young girls who have been academically and socially prominent in high school and thrust them into a situation with fewer social and cultural contacts. We must provide adequate mental hygiene and counselling facilities to help these students make adjustments to the complexities of hospital life, as well as to enable them to live a full life after graduation.—excerpt from *Nursing—a Social Institution*

Health Examination and the Worker

The statisticians of the Metropolitan Life Insurance Company report that 250,000 diabetics are employed in the United States and that the number is growing from year to year. Most diabetic workers are over the age of 40 and their absenteeism rate

is little higher than that of non-diabetics and not much of the time lost is due to their disease.

The employer and the industrial physician can do much by encouraging the employee to obtain good medical supervision, to learn the facts about the disease, how to avoid diabetic coma or insulin reaction and what to do if either impends. The employer can also aid in the early discovery of diabetics by providing for routine laboratory tests for the disease at the annual medical examination of workers or by intensive case-finding campaigns in his plants.—excerpt from *Metropolitan Information Service*

An Allied Field Experiment

A five-year experiment in medical education which may revolutionize the teaching of medicine has been undertaken by the School of Medicine at Western Reserve University. The objective is to turn out physicians who are better equipped to apply scientific knowledge for the health of humanity. The plan, which is original with the medical school, involves scrapping the present curriculum gradually and substituting a new one in which the material taught will be woven together so that from the beginning the medical student sees and feels that man as a whole being is his concern.

Deficiencies in the present educational program in medical schools include the following, according to Dr. Wearn:

- (1) Students are forced to learn a tremendous number of unrelated details.
- (2) The laborious coverage of factual material deadens initiative and curiosity.
- (3) Each individual department presents its subject matter without close relation to the offerings of other departments.
- (4) The separation of preclinical training from clinical training in the second two years tends to emphasize the differences rather than the interrelation of basic sciences and patient care.
- (5) Many teachers have attained their positions on the basis of research or care of patients and are not necessarily interested or prepared for important educational

responsibilities. (6) The medical curriculum has grown by addition of new material, has not been drastically pruned or rearranged for 30 years, and has not been reoriented extensively in spite of the great changes which have occurred in medical practice and distribution of medical services.

The project represents a serious attempt to remedy such deficiencies by improving the order, relationship, and quality of the material presented to medical students. Dr. Wearn said: "It is an attempt also to restore the proper emphasis on teaching." Commenting on the program, Dr. Millis said:

I believe that this is the most important experiment in medical education that has been undertaken in 30 years. The effect of this experiment will be felt, not only in medical education throughout the country, but also in general education where re-evaluation and change is greatly needed.—excerpt from *Public Health Economics* (March, 1950)

Sounds Familiar

We have been asked by Council to approve raising the annual subscription; such a change could not come into effect until 1951. With the overall rise of the cost of running a profes-

sional organization it is impossible to continue the present work of the College on an annual subscription of one pound. If the members at the annual general meeting vote against an increase, a drastic cut in all branches of the work and a reduction of professional and clerical staff will be required, resulting in the curtailment of expert advice and information to members personally and to the profession as a whole through such admirable activities as the Nations' Nurses' Conferences and Refresher Courses. We are not alone in facing this financial position. Most similar organizations have already increased their subscription and I cannot imagine that any of us would wish to see Council constrained to retard the work of the College because of lack of money.—excerpt from letter to Branch Members, South Western Metropolitan Branch, *Royal College of Nursing*

Publication

"Group Discussion Methods," published by the University of Manitoba, Adult Education Office, may be purchased for ten cents. For those planning their fall educational programs, this little book would be of great value.

Orientation et Tendances en Nursing

LE CANADA EN AVANT

"Le Canada," d'après un article de M. H. L. Keenleyside paru dans le *International Journal*, "est en proportion de sa population l'un des deux ou trois pays le mieux partagé du monde."

N'est-ce pas là une déclaration qui doit nous faire réfléchir le peuple canadien sur ses responsabilités en face des besoins matériels des autres pays?

Ne faut-il pas aussi reconnaître qu'un moyen d'aider les pays moins fortunés serait d'inviter un certain nombre à immigrer dans notre pays et nous aider à développer les ressources dont la nature nous a si généreusement dotés?

L'on nous envie à cause de nos richesses. En partageant nos biens avec ceux des autres pays qui sont dans la nécessité, n'éloignerions-nous pas certains dangers politiques et du même coup nous augmenterions notre pouvoir de production et ce sera à l'avantage des canadiens comme à celle de l'humanité toute entière.

Nos ressources, administrées avec une saine économie, peuvent constituer une réserve où viendront puiser ceux qui ont besoin d'abri, de nourriture, et de combustible—nos forêts, nos lacs, nos prairies offrent toutes ces ressources.

Nous sommes les gardiens de ces biens. Nous avons l'obligation de faire fructifier

ces biens et la responsabilité de les partager avec les déshérités. Le Christ n'a-t-il pas dit: A celui qui a beaucoup reçu, beaucoup sera demandé.

EN ECONOMIE — UNE NOUVELLE MANIÈRE DE VIVRE

Nous avons réussi, durant les siècles passés, à nous débarrasser de l'esclavage et l'idéal de toutes ces luttes était la liberté d'action et la propriété privée. Malheureusement, le contrôle exercer par certains individus sur de grandes richesses a créé un nouveau genre d'esclavage économique.

"Le seul moyen de sauver la démocratie des forces révolutionnaires qui menacent de la faire périr est d'appuyer le mouvement de coopérative," dit le Dr. M. M. Coady de l'Université St-Francis Xavier. Par ce moyen tous ceux qui ont travaillé à édifier une fortune ont droit d'y participer.— Extrait de *The Maritime Co-operator*

A QUI APPARTIENT CETTE RESPONSABILITÉ?

Une étude faite en janvier, 1947, dans 26 hôpitaux du Canada, révèle que le soin des malades est confié aux étudiantes dans une proportion variant de 33 à 85 pour cent et ce au détriment de leur expérience éducative.

Voilà une preuve évidente qu'il y a quelque chose qui ne va pas, non seulement dans la méthode de former les étudiantes infirmières mais aussi dans la façon dont les hôpitaux assurent les soins à leurs malades.

Les études des élèves, afin de répondre aux exigences de la médecine moderne, doivent être plus poussées, les heures de conférences et les démonstrations plus nombreuses.

Actuellement, deux méthodes d'éducation sont employées: (a) *Les heures de classes sont placées entre les heures de travail*, ce qui donne aucune satisfaction à l'étudiante ou au malades. Ce dernier se voit confier à une autre infirmière remplaçante dont l'intérêt, envers ce malade qu'elle ne connaît pas, est diminué. (b) *Le système alternatif* ou "block système," lequel peut être la cause d'indigestion mental et avec lequel la corrélation entre la théorie et la pratique est à peine impossible.

Il y a 30 ans, l'âge d'admission aux écoles d'infirmière était de 23 ans — aujourd'hui les élèves sont admises à 18 ans.

Il faut bien comprendre la nature humaine et son comportement pour être infirmière. L'on voit les personnes lorsque la crainte, l'anxiété, et la douleur les assaillent.

Les jeunes filles sortant de ses pensionnats et de nos écoles ont-elles la maturité voulu pour faire face aux problèmes qui se poseront, pour s'adapter à ce nouveau milieu bien différent de celui de l'école?

Il faut donner à ces étudiantes de l'hygiène mentale de l'orientation, afin d'aider ces étudiantes à trouver les moyens de s'adapter au milieu complexe de l'hôpital, et les préparer à vivre une vie remplie après leur graduation.— Extrait de *Nursing—a Social Institution*

UNE RÉVOLUTION CHEZ LES ETUDIANTS EN MÉDECINE

L'on va tenter durant cinq ans une expérience qui peut révolutionner les méthodes d'enseignements en médecine. Cette expérience sera faite par l'Ecole de Médecine de la Western Reserve University. Le but est de former des étudiants mieux préparés à appliquer à la santé leur connaissances scientifiques. Le programme d'étude sera changé et un autre lui sera substitué pour l'étudiant en médecine dès le début de son cours, de réaliser ce que l'homme ressent dans son psychique aussi bien que dans son physique et son moral. — Extrait de *Public Health Economics* (mars, 1950)

L'EXAMEN MÉDICAL ET TRAVAIL

Les statisticiens de la Metropolitan Life Insurance Co. rapportent que 250,000 diabétiques aux Etats-Unis exercent un emploi malgré leur maladie et le nombre de diabétiques augmente d'année en année. La plupart de ces employés ont plus de 40 ans et ils ne manquent pas beaucoup plus au travail que les autres employés et la diabète n'est pas la cause de leur absence.

L'employeur et l'industriel peuvent grandement encourager l'employé à se faire suivre par le médecin à se renseigner sur cette maladie — comment éviter le coma diabétique, la réaction de l'insuline, ce qu'il faut faire dans ces cas.

L'employeur peut aider le diagnostic précoce des cas de diabète en ajoutant à l'examen périodique de ces employés des tests de routine.— Extrait de *Metropolitan Information Service*

PUBLICATION

"Group Discussion Methods," un pamphlet de grande valeur que l'on peut se procurer pour dix sous en s'adressant à *University of Manitoba (Adult Education Office)*.

Student Nurses

Nutritional Anemia

SISTER CLARE MARIE

Average reading time — 16 min. 48 sec.

MRS. FORD, 35 years of age, was admitted to hospital by ambulance on December 16. She complained of extreme fatigue, shortness of breath on exertion, and a progressive loss of weight over a period of five months previous to admission.

Mrs. Ford was married for seven years before her first child was born. During the first years of her married life she continued to work, although her husband was steadily employed.

Small of stature, Mrs. Ford has a pleasing personality and friendly disposition. She readily adapted herself to hospital environment and was a cooperative patient during her stay in hospital. Her only previous hospitalization was for her two confinements.

MEDICAL HISTORY

Mrs. Ford had an uneventful first pregnancy in 1946, terminating in a fairly normal delivery. After Donald's birth she developed a macrocytic anemia which readily responded to treatment. (This type of anemia is frequently associated with pregnancy.) In June, 1948, she gave birth to a second son. Once again she developed anemia. As she did not gain strength or return to her usual vigor, she reported her condition to the doctor. He gave her a series of 12 liver injections over a period of two months. These injections were stated to have raised her hemoglobin to 75%.

Sister Clare Marie is a student at the School of Nursing, St. Martha's Hospital, Antigonish, N.S.

After the injections, Mrs. Ford's doctor lost contact with her from August to December. During this time she found it most difficult to carry on her regular household duties. Gradually she became overcome with exhaustion. Her legs ached so that she could no longer walk around without feeling as though they would collapse under her. Her appetite became poorer and she had shortness of breath on the slightest exertion. It became necessary for her to stay in bed for periods of three and four days at a time. The minimum of strength thus gained would allow her to get up and around for a day or two. Then exhaustion would overtake her again.

MEDICAL CARE

Mrs. Ford's condition was classified as critical at the time of her admission. It was diagnosed as severe anemia of a doubtful character, probably nutritional. Due to the far-reaching effects of this devastating condition on practically every system of the body, the immediate plan for medical care was complicated. Pertinent information had first to be secured through a series of examinations, tests, and x-rays before detailed care could be planned.

The first investigation was to have a complete blood picture analysis done. On December 17, the accompanying revealing report was filed.

Thus, there was a deficiency of over four million red blood cells, two and a half thousand white blood cells, and 60% hemoglobin.

Another analysis done three days

	Mrs. Ford's	Normal
Red blood cells.....	430,000 per cc. of blood	4,500,000 per cc. of blood
White blood cells.....	2,500 per cc. of blood	5,000-9,000 per cc. of blood
Hemoglobin.....	21%	80-90%

later showed a still greater abnormality, particularly in the hemoglobin percentage: Red blood cells—640,000; white blood cells—2,350; hemoglobin—15%.

Such an anemia could be of the pernicious type of which one symptom is the absence of hydrochloric acid in the stomach; it could be due to liver impairment; to an inability on the part of the intestinal tract to absorb the end-products of digestion; or it could be an aplastic type, that is, due to bone marrow deficiency. To arrive at a conclusion as to which was the responsible factor, the following tests and examinations were done:

Gastric analysis test; examination of feces for ova and parasites (which might be interfering with absorption); examination of the gastrointestinal tract for ulcerative areas, tumors, or cancer; liver function tests and bone marrow examination.

The gastric analysis test is made for the purpose of analyzing the contents of the stomach, thereby determining the amount of acid present. Mrs. Ford's test showed the presence of acid; hence, a diagnosis of pernicious anemia was ruled out. An examination of the feces was made for ova and parasites. There were none.

Next, a series of x-rays was taken of the gastrointestinal tract. The substance the patient is given to drink is opaque to x-ray and, therefore, allows the contour of the stomach and intestines to be depicted on the developed film. Any abnormalities can be detected. The report on Mrs. Ford's series showed her organs to be in normal condition. From all these negative results it was logically concluded that anemia was not due to an inability of the gastrointestinal tract to either receive or absorb food. It remained to be seen whether the underlying cause of the condition was to be found in the liver or in the bone marrow.

The liver plays an important role in the life of the red blood cell. It is produced in bone marrow and evolves into a mature cell through a series of migrations, passing from the infant megaloblast to an erythroblast to a normoblast to a reticulocyte to a mature red blood cell. In order to

"grow up" the cell needs an essential substance called the maturation factor (anti-anemic principle). This principle is made up of two factors—the extrinsic, which is extracted from the food eaten, and the intrinsic, which is obtained from the gastric juice. The combined essence is stored in the liver. Therefore, a diseased or non-functioning liver would interfere with red cell maturation and this would eventually lead to anemia.

The Icterus Index, the Urine Urobilinogen, and the van den Bergh were the tests done to ascertain liver inefficiency, if any.

The Icterus Index measures the ability of the liver to excrete bilirubin, a pigmented substance derived from the hemoglobin liberated by over-age red blood cells which are constantly being destroyed in the body. Bilirubin is excreted in the bile and leaves the body as part of the feces. The Icterus Index is elevated if the liver fails to excrete bile at a normal rate, whether because of mechanical obstruction to the flow of bile into the intestines or due to damage in the liver cells themselves. With sufficient elevation of the bilirubin content in the bloodstream the patient becomes jaundiced. Mrs. Ford's index was 12.6 units. The normal is 4-6 units. (With an elevation over 16 units the patient becomes jaundiced. Mrs. Ford was slightly jaundiced at this level).

The following is the mechanism of the Urine Urobilinogen test: Urobilinogen is formed by the action of intestinal bacteria on the bilirubin in the bile. A portion of the urobilinogen is reabsorbed through the intestinal wall into the bloodstream and appears in the urine. This is the basis for the test. Normally there is a certain amount present. If it is absent it may be concluded that there is no bilirubin and, hence, no bile reaching the intestines, either because of biliary tract obstruction or failure of the liver to secrete bile. If liver cells are not functioning adequately calcium bilirubinate and bilirubinoglobin are retained in the blood, the concentration becoming abnormally high. An increased urobilinogen in the urine is one of the earliest signs of liver cell damage. This test showed Mrs. Ford's urobilinogen concentration to be

1-100 units; a repeated test a week later indicated 1-20 units. The latter figures are within the normal range. It can be concluded that the patient had liver damage of a temporary nature.

The van den Bergh test checks the quantity of bile in the bloodstream. From a vein, 5 cc. of blood are withdrawn, allowed to clot, and the serum separated. It is mixed with a reagent which will turn the serum bluish-violet in color. Two types of reaction result—the direct and indirect. In the former there is an immediate reaction, a turning of the color of the serum in 10-30 seconds; in the indirect reaction the results are obtained in 1-5 minutes. The direct reaction is indicative of obstructive jaundice; the other of non-obstructive jaundice. Mrs. Ford's tests were: Direct, 55 seconds; indirect, 1-2 minutes. Thus, the results of the indirect test indicated some liver damage but not of much consequence. Evidently then, this small liver damage could not be the primary cause of such a severe anemia. On the other hand, it is very likely that the liver impairment was resulting from the anemia.

Approximately two weeks after admission, another factor in the condition of this patient called for investigation. It was noted that she was passing a very malodorous urine. A series of x-rays, examinations, and tests was done to determine the cause. A microscopic examination of a cultured specimen of urine revealed the presence of *E. coli*. This is a bacterium, the growth of which produces toxins and pus and these in turn are responsible for putrefaction. This process emits an odor.

A cystoscopic examination and a retrograde pyelogram were done to determine whether or not any pathological condition existed in the urinary organs. A retrograde pyelogram is a procedure which allows for the following: A dye is injected into each ureter by means of special catheters; the dye flows into each kidney and an x-ray is then taken. The result is a clear picture of the kidneys and ureters; if any abnormalities are present they can be easily seen. Such examinations revealed Mrs. Ford's organs to be normal excepting for the presence of a small cystocele (a sac-like protrusion on

the anterior vaginal wall caused by a sagging bladder). It was thought that bacteria from the vicinity of the urethral opening were collecting in this cystocele, breeding and causing putrefaction.

A biopsy of bone marrow was performed in an effort to determine the exact diagnosis. It is here that blood cells develop from their immature to their mature stage. It was found that there were 80% immature and only 20% mature cells. Normally about 70-80% should be in the mature state. This would give the impression that the body was lacking some essential factor that was keeping the cells from growing up. The tentative diagnosis following the bone marrow biopsy was leukemia, probably of the aleukemic type.

Mrs. Ford's temperature remained persistently elevated for a period of days, reaching a peak of 103°. Sulfa and penicillin therapy were of no avail in reducing it. Streptomycin was then administered. The temperature dropped but remained elevated to 99.4. It was not established whether the fall in temperature resulted from streptomycin or to an improvement in general body tone.

While these investigations were being carried out, the patient's immediate needs were filled. She was given liver extract—30 units b.i.d.; her diet was planned to combat her nutritional disorders. Her medications were tonic in nature, rich in vitamins. Hemograms were done regularly in order that knowledge thus gained would serve as a working basis for the introduction of newer methods of handling the case.

Mrs. Ford grew progressively worse and signs of congestive heart failure began to develop. Such a condition occurs because, due to the severe anemia, the heart muscle receives an insufficient supply of blood. Not being able to pump blood adequately, congestion results in the chest cavity. This emergency state of affairs was treated by the administration of oxygen and a blood transfusion. (The latter had been withheld as by transfusing the patient her blood investigation would be interfered with.) These therapies proved to be life-sav-

ing for in a few days Mrs. Ford's condition was improved.

Injections of folic acid were begun on January 17. (This is a purified synthetic preparation of the maturation factor.) It was given intramuscularly, 40 mg. daily. The usual dose is 10 mg. daily. The next day the dosage was increased to 45 mg. A blood examination on January 24 showed a 13% increase in hemoglobin, a red cell count of 1,920,000 and a white cell count of 7,000.

The diagnosis of leukemia had not been completely outruled as yet. It is generally believed that folic acid therapy is valueless where a condition of leukemia exists. As there was a pronounced improvement in Mrs. Ford's hemoglobin following its administration, it was decided to examine the bone marrow again. The picture at the second examination was the exact opposite of the first. This time 80% of the cells were in the mature state; 20% immature. On January 31 the hemoglobin reached 47%. A week later it reached 57%.

These latter findings confirmed the diagnosis of nutritional anemia complicated by pregnancy.

NURSING CARE

In caring for Mrs. Ford every skill and technique of nursing had to be practised. After admission her appetite became very poor. As the underlying cause of her condition was lack of nutrition it was most essential that every effort be taken to encourage her to eat. Food was attractively prepared and tissue-building foods, as well as those rich in vitamins, were given in plentiful quantities. Supplementary feedings in the form of milk shakes and orange juice were given between meals.

Due to poor circulation, Mrs. Ford's skin was in danger of pressure sores developing. Her anemic condition caused her to be very inert; thus, for the greater part of the time, she would lie motionless. This was another factor that would have quickly led to a break-down of the skin if nursing care had been indifferent. It was necessary to change her position frequently and

to massage those parts of the body that were sustaining most of the pressure.

When congestive heart failure occurred the blood from the pulmonary circulation was dammed back to the lungs, resulting in congestion in that area with resultant difficulty in breathing. The accumulation of fluid in the lungs and bronchioles caused severe spasms of coughing. Nursing care called for the administration of oxygen, elevation of the head of the bed to facilitate breathing, and giving an expectorant to aid in the spasms of coughing.

As this patient had a persistent fever, her mouth and lips became very dry; the latter also became excoriated and bled easily. This condition was further complicated by the coughing. Regular and special mouth hygiene had to be given. Liquid paraffin was applied to the lips very frequently as, bleeding and cracked, they were a painful source of discomfort to the patient.

As Mrs. Ford was extremely ill during the first part of her hospitalization, it was necessary to take care of her personal hygiene for her. The necessity for this care was further emphasized by the malodorous urine. It was also important to watch out for orthopedic deformities which could result from the patient maintaining the same position in bed over a long period of time.

Mrs. Ford improved steadily during the latter part of her hospitalization. She was given a diet high in calories and gained weight as a result. Her one ambition was to make a complete recovery so that she could return to her home. Towards this end she cooperated splendidly.

POINTS TAUGHT

Mrs. Ford was cautioned to watch her general health after she returned to her household duties and to notify her doctor without delay if she felt she was not up to normal.

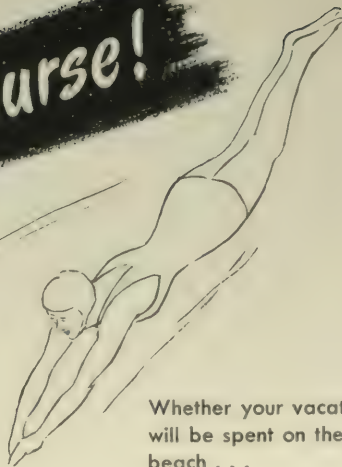
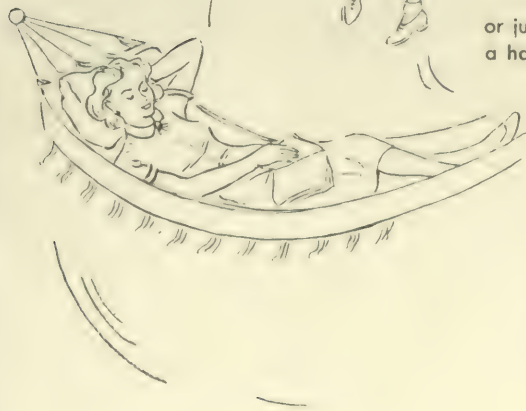
She was instructed to pay special attention to her diet, taking her meals regularly and selecting those foods which are good body builders.

Happy Vacation Nurse!



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MONTREAL
AUGUST
1950



THE CANADIAN NURSE

C.N.A. at U.B.C.

NURSING THE INDIANS



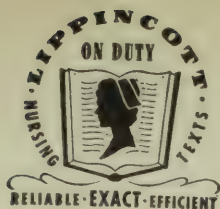
WHAT NEXT?

See Page 612

Photo by Lee Holt



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The Canadian Nurse

VOLUME 46

NUMBER 8

AUGUST, 1950

NEW PRODUCTS.....	606
C.N.A. AT U.B.C.....	611
HELEN McARTHUR, PRESIDENT.....	620
NURSING ON CANADA'S ROOFTOP.....	<i>I. Maison</i> 621
A HEALTH SURVEY IN THE FAR NORTH.....	<i>M. E. McCann</i> 626
HIGHLIGHTS OF TREATY AT OXFORD HOUSE.....	<i>J. Edwards</i> 632
THE NURSE AND THE LAW.....	<i>C. Ledoux</i> 635
AIMS OF PROFESSIONAL EDUCATION.....	<i>M. E. Henderson</i> 638
DEVELOPING THE SOCIAL AND HEALTH ASPECTS OF NURSING.....	<i>I. Lawson</i> 641
HIDDEN DIABETES WITH PSYCHOSIS.....	<i>C. Macleod</i> 643
THE VALUE OF VISUAL AIDS.....	<i>Sr. M. Rosarie</i> 646
LES AIDES DANS L'EQUIPE EN NURSING.....	<i>A. Lindblad and M. Struve</i> 649
TRENDS IN NURSING.....	655
ORIENTATION ET TENDANCES EN NURSING.....	656
LYLE CREELMAN WRITES.....	658
LEARNING BY SEEING.....	<i>R. B. Brown and S. E. Gibson</i> 660
BOOK REVIEWS.....	662
NEWS NOTES.....	670
OFFICIAL DIRECTORY.....	680

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association

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PIONEER MEAT EATER

(5 years later)



Bill Purvy at one year. He became a participant in Swift's first meat-feeding test at 4½ months.

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Says Bill's mother, and it's evident from the picture of Bill above. His mother reports that he liked Swift's Meats for Babies from the beginning.

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Current Clinical Meat Feeding Studies

REPORT No. 4

EFFECT OF MEAT IN THE DIET OF INFANTS AND YOUNG CHILDREN

Results of this study indicate that meat promotes hemoglobin and erythrocyte formation. These findings were revealed in a preliminary report published in the J.A.M.A. (134 1215 (1947)). The present studies are a continuation of the work reported in this article.

This study is part of an extensive clinical research program now being conducted through grants-in-aid made by Swift's.

ommend Swift's Meats for Babies in the early weeks of life — to provide the complete, high-quality proteins and iron every infant needs every day.

Swift's appetizing variety includes: beef, lamb, pork, veal, liver and heart—to help infants acquire a taste for variety and form sound eating habits.

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Between Ourselves

Three separate accounts of the provision that is made for supervising the health of our **Indian population** are featured in this issue. They make very easy reading since they show the human interest side of the service so clearly. Readers should realize, however, that there are thousands of Indians living close to the more heavily populated areas too. They perhaps appear less romantic than those in the northern areas, being much less nomadic.

According to the best available estimates, before the white man came to what is now known as Canada there were something over 200,000 Indians. Though the present population figure is considerably below that number, the popularly-held opinion that the race is disappearing is not in accordance with facts. During the 20th century the trend has been upward with a gradual but fairly steady increase. Much of the credit for this improvement can be given to the health programs that have been sponsored by the Federal Government. Several hospitals are maintained by the Indian Affairs Branch for the exclusive use of the Indians. In addition, provision is made for their hospitalization in municipal hospitals in many areas.

Reference is made in the stories we have included here to "Treaty" moneys. Perhaps some of our readers are not aware of the derivation of this term. In the older, more thickly settled parts of Canada—Ontario, Quebec, and the Maritimes—the history of the Indians has been one of slow development with that of the communities near which their reserves were located. In Western Canada, the situation has been different. There, the rapid spread of civilization necessitated prompt and effective measures to protect the rights and privileges of the Indians. Treaties were made with the various tribes whereby the Indians ceded to the Crown their aboriginal title and interest in the land. In consideration of this cession, the Federal Government promised certain benefits: adequate territory set aside as Indian reservations; cash grants made; annual payment of annuities on a per capita basis—the "Treaty" money; assistance in agriculture, stock-raising, hunting, trapping, etc.; the

education of Indian children; facilities for health protection. No treaty has been made with the Indians of British Columbia, except in the Peace River Block, but their welfare has received no less attention.

The *Indian Act* provides for the enfranchisement of Indians. However, when an Indian is enfranchised he ceases to be an Indian under the law and acquires the full status of Canadian citizenship. This loss of special protection under the *Indian Act* has been a curb to the general practice of seeking enfranchisement.

* * *

Recently, a letter came to us from a nurse who has been a regular subscriber to the *Journal* ever since her graduation in 1912. This past year while working on her thesis for her master's degree, she examined every issue since the first number of *The Canadian Nurse* was published in 1905, searching for material dealing with organization and administration. Since you, the nurses of Canada, have been responsible for the calibre of the material that has been published through the thousands of painstakingly prepared articles you have contributed, we want to pass on to you the compliments paid by this authority: "I feel that Canadian nurses have made a large contribution to literature in nursing, especially in the therapy area. I have been impressed by the number of American nurses who use this magazine and value its contents. In addition to the many fine articles, I have gleaned much information from the book reviews and from your advertisers' columns. While in India as a missionary . . . I found these two sources of particular help in keeping up with the new publications and new items of equipment."

* * *

This issue contains the last of three instalments of Sub-Inspector Carl Ledoux' interesting and different article, "**The Nurse and the Law.**" If you did not receive the June and July issues containing the rest of this account, write in for your copies. Single copies sell for 25 cents each. Send the money with your order, please.

Some people speak from experience; others, from experience, don't speak.



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New Products

Edited by **PROFESSOR F. N. HUGHES**

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DANILONE

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Indications — For prophylaxis and treatment of thromboembolism and thrombophlebitis. Has a latent period of action of about 24 hours and period of recovery of 48 hours.

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INOSITOL TABLETS

Manufacturer — Webber Pharmaceuticals, Toronto.

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Manufacturer — Sharp & Dohme (Canada) Ltd., Toronto.

Description — Each six Cadrosan Tablets contain:

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Manufacturer — Officinals of Canada, Lachine, Montreal 32.

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Sol. Glycero-hydroxy-ethylic. Citrat.....	20.-

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Indications — For nutritional anemias of infants and children.**Administration** — 1 to 2 cc. daily.**CAM-CELL TABLETS****Manufacturer** — Webber Pharmaceuticals Ltd., Toronto.**Description** — Sodium Carboxymethylcellulose 225 mg. and Magnesium Oxide 75 mg. in each tablet.**Indications** — Peptic ulcer therapy to lower gastric acidity. Has prolonged effect with no adverse effects.**THEPTINE****Manufacturer** — Smith Kline & French; Canadian distributors: The Leeming Miles Co. Ltd., Montreal.**Description** — A liquid preparation containing Dexedrine Sulphate, Thiamine, Niacin, and Riboflavin.**Indications** — A restorative for patients in whom mental depression and nutritional inadequacy manifest themselves as apathy, lethargy, and physical debility. It is particularly suitable for children, invalids, convalescents, and the aged.**Administration** — Usually one teaspoonful (5 cc.) three times a day, although some patients may require larger doses for best results. It is important to note that Theptine should be taken immediately after meals. If this dosage time is faithfully observed, there should be no interference with appetite.**RUBRAMIN CAPSULES****Manufacturer** — E. R. Squibb & Sons (Canada) Ltd., Montreal.**Description** — Each capsule supplies 25 micrograms of vitamin B₁₂ for oral administration.**Indications** — Recent studies suggest that many cases of pernicious anemia and certain other macrocytic hyperchromic anemias respond favorably to oral use of B₁₂ in large doses.**Administration** — Dosage varies greatly. Initial dose of 150 mcg. daily (6 capsules) is suggested. If, after a week or 10 days, the blood picture has not improved, dose should be increased to 300 mcg. daily. If not improved after 3 weeks, intensive parenteral B₁₂ therapy should be started immediately. If improvement is shown on oral Rubramin, therapy should be continued until the blood picture reaches normal.**RONIACOL****Manufacturer** — Hoffmann-La Roche Limited, Montreal.**Description** — Peripheral vasodilator for oral administration. Each tablet contains approximately 50 mg. of tartaric acid salt of beta-pyridyl-carbinol (the alcohol corresponding to nicotinic acid). Longer lasting action than nicotinic acid, yet less danger of severe flushing or by-effects.**Indications** — Vascular spasm, Raynaud's disease, intermittent claudication, varicose ulcers, acrocyanosis, chilblains, migraine associated with vascular spasm and Ménière's syndrome.**Administration** — Treatment should be started with 1 tablet 3 times a day. If necessary the dosage may be increased to 4 or more tablets daily.

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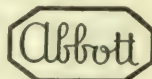
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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX

NUMBER EIGHT

MONTREAL, AUGUST, 1950

C.N.A. at U.B.C.

Average reading time — 14 min. 24 sec.

ONCE AGAIN the biennial convention—it was the twenty-fifth this time—has come and gone. Registration was high, yet so extensive is the campus of the University of British Columbia that there never appeared to be crowds, excepting when the participants, who numbered nearly a thousand, lined up for lunch in the cafeteria. Nature was exceedingly kind. Warm sunshine poured down most of the time. Those who had come prepared for the worst in weather found themselves uncomfortably warm in suits.

The greater number of the members who flocked in from all parts of Canada lived right on the campus. Union College housed the Executive Committee, while the rest of the members were quartered in Acadia, Youth Training and Fort Camps. Living accommodation was not exactly deluxe in quality but none complained. How could they with the incomparable view of mountains and sea from every window and door? One nurse was heard to exclaim that the views were so beautiful they did not seem real. The mountains at sunset looked to her like some vast, painted back-drop!

Very real regret was expressed by one and all that British Columbia's gracious president, Sister Columkille, was unable to be present, owing to illness. Her place was ably filled by first vice-president, Esther Paulson.



Holt

MISS HELEN RANDAL, who was executive secretary of the R.N.A.B.C. when the last convention was held in Vancouver in 1936, views photos with MISS ALICE WRIGHT, present officer.



Every possible detail for the comfort, convenience, and entertainment of the visitors had been perfected by the capable chairman of the Arrangements Committee, Mrs. Alison Wyness, and her well-coordinated batteries of assistants. At every session squads of student nurses, in their rustling uniforms, acted as ushers and were tireless in their enthusiasm to help. It was rumored that competition was so keen among these youngsters for the privilege of attending the sessions that new groups were given the opportunity each day. Truly, the convention was a great event in the lives of many people.

The deliberations of the Executive Committee were conducted during the three days prior to the week of convention. To celebrate on the Saturday evening, the members of the Executive were the guests of the Council of the Registered Nurses' Association of British Columbia at a unique party held at Steelhead Lodge, some 20 miles from Vancouver on beautiful Coquitlam River. Enormous steaks were barbecued over glowing coals by the genial host, Carl Jacobs, and served right out of doors. The aroma was tantalizing as the food was prepared. Since two sittings were required to accommodate all the guests, the less fortunate "second sitters" went for walks through the tranquil woods. Such steaks! Such gallons of coffee! It was, indeed, a royal feast!

SUNDAY

In the afternoon, Elinor Palliser, director of nursing at the Vancouver General Hospital, entertained at tea and afforded the visitors an opportunity of inspecting the commodious new nurses' residence that is nearing completion. One feature that aroused considerable envy was the sun-deck on the roof—nine storeys up.

A special service for the nurses, which was held at Christ Church Cathedral that evening, was very well attended. To mark the occasion, the scripture lessons were read by Miss Martin from St. Paul's Hospital and Miss Palliser. An unusual feature of

the service was the unveiling and dedication of a beautiful stained-glass window given in honor of "the nurses of Vancouver who serve in war and peace."

MONDAY

Verbal greetings of welcome were brought to the opening session by Dr. G. F. Amyot, Deputy Minister of Health and Welfare for B.C., Mayor C. E. Thompson, and Dr. N. A. M. MacKenzie, president of the University of B.C. We were very honored to have Mrs. Elizabeth K. Porter, newly elected president of the American Nurses' Association, with us all week. Elizabeth Summers represented the nurses of Newfoundland in this their first convention with their fellow Canadians. Another welcomed visitor was Virginia Alcott of the faculty of the School of Nursing of the University of Washington, Seattle. Miss Alcott gave invaluable assistance with the work conference that discussed the evaluation and accreditation of schools of nursing. An added feature of the first day was the reading by the president, Ethel Cryderman, of the citations presented on the occasion of the awarding of honorary degrees by the University of British Columbia this year to two well-beloved and justly famous Canadian nurses. In order that these may be shared with all the nurses of Canada, the citations are recorded here in full:

Mr. Chancellor, I have the honor to present for the degree of Doctor of Science, *honoris causa*, **Marion Lindeburgh**, Director of the Graduate School of Nursing at McGill University, who has brought selfless devotion, infinite persistence and rare distinction of mind and character to her lifetime task of advancing the art and science of nursing. As the academic governing body of the first University in the British Commonwealth to institute a degree course in nursing, the Senate of this University, in presenting her for this degree, pays tribute to her unconquerable spirit, her pre-eminence in this field, and gladly acknowledges the debt which contemporary nursing education owes to her.



Sunday's Photos, Vancouver

Scene in the Auditorium at U.B.C. — June 26, 1950.

Mr. Chancellor, I have the honor to present for the degree of Doctor of Law, *honoris causa*, **Laura Holland**, whose compassion for the unprotected, made effective by abundant common sense and great executive ability, has been responsible in large measure for our provincial child welfare programme and has contributed greatly by thought and action to the increasing efficiency of our national welfare services. In presenting Miss Holland for this degree the Senate pays tribute to one who has not only exemplified the highest devotion to human welfare herself but who has also the rare faculty of inspiring a like devotion in others.

The presidential address focussed attention on the problems of nurse shortage that still are pressing us on all sides. Miss Cryderman predicted that—

As the implementation of the National Health program progresses, the current acute shortage will worsen. . . . It is abundantly clear that, with the current and the potential nurse shortage, immediate and positive action is required to conserve nurse power, to increase the number of nursing personnel, and to ensure the permanence of essential nursing service to the people of Canada.

Miss Cryderman's address will be printed next month.

A most enjoyable reception was held at Stanley Park Pavilion in the evening when the visitors were the guests of the alumnae associations of the hospitals in Vancouver and New Westminster. In the sunset after-

glow the guests strolled through the richly-scented rose garden, visited the various memorial groupings, or were awed by the enormous trees that abound in the Park. And, thank goodness, there were no mosquitoes!

TUESDAY

This morning's session featured a panel discussion on the aims and accomplishments of the Metropolitan School of Nursing. Following the very lucid explanations by the director of the school, Nettie Fidler and her assistant, Eleanor Martin, it was recommended from the floor that each provincial association endeavor to arrange a similar program at district or other meetings to acquaint as many nurses as possible with the developments that have taken place. It was even regretted that a recording had not been made of the whole panel for future distribution and information. Much food for thought was contained in the vital report of the Educational Policy Committee.

Work conferences and general interest sessions commenced at two o'clock. There was considerable regret expressed that the members had had to choose "either/or" since so much valuable material was presented in both sessions. Particular mention should be made of the splendid neurosurgical demonstration put on by Alice Major of the Montreal Neurological Hospital. It is hoped that these procedures can be recorded on a film



Holt

Discussing the Metropolitan School of Nursing—left to right: A. MACLEOD, SR. ST. ALBERT, M. LINDEBURGH, N. FIDLER, M. KERR, A. WRIGHT, H. LAMONT, T. HUNTER.

so that the technique may be shared by a much larger body of nurses.

A special treat at the evening assembly was the concert put on by the nurses' glee clubs from the local hospitals. They were followed by a most provocative address delivered by Dr. Martin Cherkasky. In discussing the topic, "A Program for the Care of Persons with Chronic Illness," Dr. Cherkasky declared that there is a danger that we may be becoming too scientific and less human in our nursing care. "Humanity and kindness are such necessary ingredients," he said, pointing out the value of "T.L.C." in the emotional as well as the physical well-being of those suffering from long-term illnesses. "Many patients cannot be economically rehabilitated. Every one, however, should be given some incentive to improve his own lot. It is dreadful for any patient to feel he is abandoned to his fate."

An informal coffee hour, sponsored by the Greater Vancouver District and the Vancouver Chapter, concluded the day's activities. It was still early enough in convention week that many members had not had an opportunity previously to greet their friends from distant points. For some it was the first reunion in many years. So squeals of joy were heard on all sides as familiar faces appeared.

WEDNESDAY

A report that will undoubtedly have far-reaching repercussions in our professional associations opening the morning session. Fully endorsed by all the provincial associations, it was proposed that a special committee and a director be appointed to make what is being called, for convenience sake, a *Structure Study*. The actual terms of reference have yet to be worked out in detail but essentially the plan includes a careful analysis of present and proposed activities in the C.N.A.; the relationships of the C.N.A. to the provincial associations which, by federating, compose the C.N.A.; what are national responsibilities, what are truly provincial, etc. It is hoped that this committee



Holt

Joy be! The R.N.A. will help us get better working conditions.

will be ready to present a completed report at the next biennial.

Following the report of the Labor Relations Committee in which was incorporated the first statement of personnel policies to be officially adopted by the C.N.A., a "documentary" play was presented by the Victoria Chapter. Entitled "Yours for the Asking," this skit dramatized the feeling of frustration experienced by many general staff nurses over the inadequacy of working conditions and salaries, and their jubilation when steps, initiated by their R.N.A., resulted in steady improvement and progress. The prologue stated:

In the world of nursing, we are just now beginning to feel our power and it is going to need wise guidance if it is not to be used solely for our own ends. In B.C., that guidance is available through the Select Committee of the Registered



Holt

SQUADRON LEADER FRANCES OAKES "ambushed" by Dominic Charlie, his wife and son.



Sunday's Photos, Vancouver

In the Banquet Hall (Head Table in the distance) — June 28, 1950.

Nurses' Association. Indeed, it was for this very purpose that this committee was formed in 1946. Its members have studied labor legislation in all its phases in order to provide far-sighted leadership in the many problems facing nurses today.

The 1,300 nurses who attended the banquet held this evening will have a vivid recollection of the head table party being led down the aisle to the beat of Indian tom-toms. The banquet committee had an enormous task on their hands in preparing the interesting souvenir menus. On thinnest plywood the symbolic design reflected some of the historical developments of the hostess province. Joyce Rea, the nurse who had executed the book-plate design for the War Memorial Committee, was the artist.

A vigorous effort is being made to preserve the ancient Indian ceremonial dances. Several of these were demonstrated to the interested audience before the serious business of the Mary Agnes Snively Memorial lecture commenced. The accompanying photograph caught much of the atmosphere that was created.

Dr. Charlotte Whitton had aroused considerable curiosity by the choice



Holt

The Banquet Committee: B. McCANN, J. JAMIESON, A. WYNESS.

of her title "Trumpet in the Dust." Her scholarly, inspirational address will be printed in full next month. Later, reprints will be available on request from our National Office.

THURSDAY

Each of the special interest committees had extensive reports to consider during their sessions held



Holt

Steve Charlie beats the tom-tom while Isaac Jacobs, Dominic Charlie, and Mrs. Jacobs dance.

this morning. The Public Health Committee studied the report of the Bailey-Creelman Survey which has just been published. Institutional Nursing reviewed an extensive study of the present thinking and practice regarding the ratio of nursing assistants to graduate personnel in the hospital field. Private Nursing (and it will be noted that, with the adoption of an amendment to the C.N.A. By-Laws, the word "Duty" is henceforth eliminated) gave careful consideration to a proposed constitution and by-laws for community registry organizations.

At the noon hour, the R.N.A.B.C. Council was again the hostess this time to the National and Provincial Secretaries. The president and editor were also invited. During the luncheon, discussion developed on the international crisis and the best method of alerting the C.N.A. in the event of Canada becoming seriously involved. A small group was authorized to summarize our thinking and to prepare a resolution. This was presented to the general assembly at its final session.

Through the courtesy of the commanding officer of *H.M.C.S. Ontario*, tours were arranged over this ship during the evening. A very large number took advantage of the opportunity for a salt water cruise up Howe Sound on another vessel. The evening was so beautiful that most of the

participants felt an urge to return again to the Pacific Coast for a longer voyage.

FRIDAY

A re-arrangement of the program placed the address by Florence H. M. Emory in the morning session. A widely-versed authority on the activities of the I.C.N., Miss Emory spoke with emphasis and conviction on the role of "The International Council of Nurses—A World Force in Nursing." This paper will also be found in our September issue.

The summaries of the ten work conferences were presented after lunch. The most significant factor emerging from these reports was the feeling that the time was too short to permit the adequate exploration of the avenues of study that were opened up. Various suggestions were voiced as to how this difficulty could be overcome, such as a period of two or three days immediately preceding or following the convention. There was no question but that such work conferences were a popular addition to the regular program. Some advocated that, since the C.N.A. has demonstrated the effectiveness of this form of program, it should now be developed in conjunction with provincial rather than national conventions. This whole matter will be considered by the new executive.

FINALE

No report of the convention would be complete without some comment on the splendid representation from the student body in our schools of nursing. With over 80 registered, every province excepting New Brunswick and Nova Scotia was represented. Indeed, Prince Edward Island had six students there. For the first time, one of our French schools of nursing, Notre Dame of Montreal, sent two students. Their special program was launched with a dinner on the first evening, sponsored by the Student Nurses' Association of B.C. Serious discussion of their problems highlighted their own work conference. They were prepared to tackle almost any topic presented with candor and



Holt

Nurses inspect the 42-foot scale model of H.M.C.S. Ontario. Shown here are: LIEUT. SALLY TROTTER; LIEUT. W. H. DAVIDSON, R.C.N. (R), EXECUTIVE OFFICER, H.M.C.S. Discovery; MRS. W. J. MACKENZIE.



At the Student Nurses' Dinner Party.

Holt

a surprising degree of maturity. They heartily endorsed the development of student nurses' associations under the egis of each provincial registered nurses' association.

The final episode of the convention came around four o'clock when, the new slate of officers, chairmen, and sisters having been announced, Miss Cryderman called the president-elect, Helen McArthur, to the platform. It was a solemn moment as the president's charge was given. Later, flanked by her vice-presidents, the new president received the gavel—the symbol of office—from the re-

tiring president, who said, "In the name of the Association, I leave the affairs of all of us in your capable hands."

To Miss F. Verret was accorded the privilege of extending an invitation, on behalf of the Association of Nurses of the Province of Quebec, for the 1952 general meeting to assemble at the Chateau Frontenac in historic Quebec City. Let's all be there!

Copies of any of Lee Holt's pictures (9" x 7") may be secured for 75 cents each by writing him at 1915 Haro St., Vancouver.

Alberta

The following news has been received concerning staff members of the Alberta Division of Public Health Nursing:

Laura Graham, Dean of Women, School of Agriculture, Vermilion, and *Margaret M. McKim* from the School of Agriculture, Olds, are serving for the summer months in the districts of Tangent and Worsley, respectively. *Mina T. Pool* has been appointed to the Athabasca health unit at Colinton. *Marion Story* is with the Child Welfare Clinic, Medicine Hat. *Jeannette McInnis*, New Brigidon, has resigned to be married. *Olive F. Watherston*, Tangent, has resigned and left on an extended trip to England. *Amy L. Conroy*, Lindale, and *M. E. Hagerman*, Medicine Hat, have both retired from the staff after many years of service. *Helene B. Janson* of Plamondon has resigned. *Jean S. Clark* is sailing for Scotland on an extended leave to take post-graduate work in Glasgow.

Good Light Needed

According to Luckiesh and Moss, who have done much research on lighting needs, workers in various occupations require foot-candles of illumination as follows:

100 foot candles or more—fine needlework, fine engraving, fine assembly, and sewing on dark goods.

50 to 100 foot candles—proof-reading, drafting, watch-repairing, fine machine work, average sewing and needlework.

20 to 50 foot candles—clerical work, ordinary reading, bench work, average needlework on light goods.

10 to 20 foot candles—ordinary office, factory, reading, sewing work.

A light meter, which is an electric cell actuated by a light beam which causes a needle to move along a calibrated dial, can be used to measure the number of foot candles in any situation.

—DR. LEONARD W. JONES

Helen McArthur, President

THE APPLAUSE of many hundreds of nurses, on June 30, 1950, welcomed newly-elected **Helen Griffith Wylie McArthur** to the presidency of the Canadian Nurses' Association.

Our new president is widely known all across Canada and to nurses in many parts of the world. Born in the southern Alberta community of Stettler, Helen McArthur represents the fourth generation of her family to be born in Canada since the original ancestors migrated from Scotland. Gay, light-hearted, always ready for some fun, young Helen romped through her years at public and high school, winning high marks in casual style.

When it came time to think of going to university, Helen McArthur decided an ordinary arts course did not interest her. She enrolled in the School of Nursing at the University of Alberta, completing in 1933 her undergraduate training at the University Hospital, Edmonton. Those were the lean years in university financing. Since no final year nursing courses were currently available at the U. of A., she journeyed to the University of British Columbia where she majored in public health nursing, receiving her B.Sc. degree from Alberta in 1934. Six years later she was awarded a Rockefeller Fellowship for post-graduate study and secured her

M.A. from Teachers College, Columbia University, New York, specializing in supervision and teaching.

Miss McArthur's first appointment in 1934 was as senior public health nurse with the Foothills Health District, High River, Alta. Here with five small urban communities and the surrounding rural area as territory she assisted with the intensive, generalized program that was being developed. Her appreciation of the value of good public relations is rooted in the experience she secured there in interpreting a public health nursing program to the community.

In 1937, Miss McArthur's restless spirit urged her to launch out into a new area in northern Alberta to carry on a rural generalized program which included all aspects of maternity care as well as the usual morbidity services. Far removed from the nearest doctor, she had many weird and wonderful experiences during the two years she was stationed at Kinuso. All-night rides in the caboose of freight trains, struggles with a cook-stove that would smoke prodigiously but seldom get really hot—this pioneering effort hardened Miss McArthur's determination to improve the lot of the nurses working in remote settlements.

Following her return from study in New York, Miss McArthur was appointed to the faculty of the University of Alberta. For four years she was acting director of the School of Nursing. In 1944, she was given her opportunity to expand the provincial nursing service when she was named director of the Public Health Nursing Division of the Alberta Department of Public Health. Two years later, Miss McArthur moved into a wider sphere of activity when she was appointed to her present position as national director of nursing services with the Canadian Red Cross Society, with her headquarters in Toronto. The recent flood and fire disasters have meant busy days and nights.



HELEN MCARTHUR

A firm believer in the inherent responsibility of nurses to participate in the activities of their professional bodies, Miss McArthur has filled many offices with enthusiasm, energy, and accomplishment. She worked up through various levels to become first vice-president of the Alberta Association of Registered Nurses in 1946. In 1944 she became chairman of the Public Health Section of the C.N.A. and simultaneously was elected chairman of the Public Health Nursing Section of the Canadian Public Health Association. It is characteristic of our new president that she filled her role in both of these offices with a level-headed leadership that resulted in considerable progress. In 1948 she was appointed convener of the C.N.A. Public Relations Committee. She has been one of the representatives of

the Red Cross on the Demonstration School Administration Committee since its inception.

Being a well-balanced individual, Miss McArthur finds time in her busy life to play and enjoy herself. An avid reader, fond of music, she broadens her mental perspective through many community contacts, including membership in the Zonta Club of Toronto.

This is our new president! Well versed in nursing affairs all over Canada, acutely aware of the need for progressive leadership in nursing, a fluent speaker, a dynamic personality, Miss McArthur warrants our whole-hearted, loyal, and enthusiastic support as she begins her new tasks as president of the Canadian Nurses' Association. She will not fail us. We, the nurses of Canada, must not fail her.

Nursing on Canada's Rooftop

IVY MAISON

Average reading time — 9 min. 36 sec.

SCATTERED across northern Canada, from Coppermine and Fort McPherson within the Arctic Circle to Eskasoni in Nova Scotia, are hospitals, nursing stations or health centres, and dispensaries, established by the Department of National Health and Welfare's Indian Health Services' to give aid to the Indian and Eskimo population who live or wander far from the more thickly populated areas. Although the Indians and Eskimos are very dissimilar, they are, for legal purposes, grouped under the one name of Indians.

The Indian hospitals are operated in much the same way as any community hospital but the nursing stations are another matter, with an interest all their own. They are small buildings with accommodation for not more than four short-term or emergency cases and with living quarters for the nurse-in-charge (a graduate) and her assistant—a highly

experienced practical nurse who combines that role with housekeeping. In addition to the two nurses, a local woman is employed to do the heavier housework and a man to look after fires and water supplies. The latter two people usually live out.

The station is the particular responsibility of the nurse and the surrounding district is her little kingdom. The department's doctors pay periodic or emergency visits but it is the everyday duty of the nurse to look after the health of the natives, young and old. To the native she is a *Very Important Person*. He relies upon her in the event of sickness or accident to himself or his family.

Prenatal and well-baby clinics are pet projects of the nurse. They are organized and held regularly. She also operates out-patient clinics to which come an assortment of cases ranging from pediculosis to ingrown toe-nails, from infected eyes to cut fingers.

Most of the nurses are in favor of visiting the patients in their homes. By this means, cases of sickness are often found which would otherwise go unreported. Also it is often possible for her to do something about improving unhealthful conditions in the homes.

The schools are another fruitful field for the nurse. With the wholehearted cooperation of the teachers, during the examination of the children she can keep a watchful eye on these small individuals to see that they get immunization against the preventable diseases, prompt medical attention when they need it, and some supervision over their nutrition. The family allowance provides money towards the Indian child's welfare just as it does for the white youngster. In northern areas the cheque is placed to the credit of the family with the local trader, who is usually of one mind with the nurse as to what constitutes nourishing food for juveniles. Papa couldn't chisel a can of tobacco on the children's food account, even if he so desired.

In her area, the nurse is usually one of a group of white people numbering anywhere from 20 to 100. Most of them are engaged upon some project which will have a beneficial impact upon mankind in general. Doctors, scientists, meteorologists, radio men, armed forces and R.C.M.P. personnel, traders, Indian superintendents, and independent white trappers, stationed in these isolated parts of Canada, depend upon each other for social activities. Life may sound lonesome but the Northland has a way of getting into the blood of those who have spent any length of time there and it stays with them forever. The first three months of a nurse's sojourn are the deciding ones—it is the North against the attractions of the friends and good times she left behind. After the first year, nothing but matrimony is likely to remove her. It has happened occasionally that, unless she has married someone she met up there, she will talk about her experiences so persuasively that she converts her husband and takes him back with her.



NFB Photo

Solace and care for a youthful patient.

The Indian is an interesting and contradictory character. He is, by turns, likable and exasperating, kindly and mean, sometimes cooperative and often just plain cussed, always childlike in his emotions and understanding and usually indolent. He loves attention and bandages—lots of both! One day a stalwart presented himself at a nursing station, his hand and arm heavily swathed in bandages and the arm supported in a sling. When layer after layer of cloth had been removed, the nurse found that he had a fish-hook embedded in his middle finger. She gave him a local anesthetic and, with a scalpel, made a clean cut in the finger and removed the hook. She dressed the finger and the brave went happily on his way minus, however, a few yards of wrapping.

Pneumonia is of fairly high incidence among the natives and various forms of influenza quickly develop into pneumonia, so the nurses are particularly alert to any outbreaks of the

disease. One Indian woman had been visited on one occasion. She was found to have a cold, with no apparent complications. The next day, another woman came to the station and, in her broken English, announced that her friend was "Awful sick! Maybe die!" Then she put on a really expert imitation of gasping, of drawing a long, shuddering breath and groaning. The nurse lost no time in calling an Indian with a canoe to take her across the choppy half-frozen lake. Huddled at the bottom of the canoe under a tarpaulin, she felt the icy water splashing over her and she could see that the Indian was having difficulty in making a turn. When they reached the opposite shore, nurse, tarp and canoe were frozen together. However, she got herself organized and made her way up the hillside to the cabin at the top. Inside she found a stove burning warmly—and her patient sewing, breathing quite calmly and evenly! As the nurse thawed herself out at the fire, she did some thinking,



Dressed up for Clinic Day.

National Health & Welfare Photo



Photo by Richard Harrington

Winter attire. Note the "snow door-way."

instead of hitting the roof as most people would have done. She thought of this woman alone up here with her three children, her husband far away on the trapline. She was just *lonely*!

Along with a few pills for the cold went friendly words in the native tongue and a kindly touch of the nurse's hand. Then the nurse petted the little children before she set out once again on her trip across that dark angry lake. She knew that her visit and her friendly talk had done more for that lonely Indian than any medicine could do. She even managed a grin as she thought of the histrionics of the woman who had come to call her. In addition to her standard equipment of skill, courage, patience, and understanding, the nurse needs a good workable sense of humor that can, on occasion, be used against herself.

If the natives like the nurse, she can wield a very strong influence over them. Not only will they bring the family to the clinics for examination and immunization, take medicine she deals out for them, but they will even go to the length of *washing themselves*, sometimes approximately daily. The

Northern Indian regards water as an excellent medium for floating his canoe or for holding fish for him to catch, but he sees no useful purpose in removing the natural accumulation of grime from his own hide. After all, it just collects there again. However, if the nurse wishes it, he'll go along with the gag. These white people are funny!

In spite of the native's antipathy to soap and water, he has developed a great confidence in the immunization plans of the government to protect his children from preventable diseases. Time was when an epidemic could strike an Indian or Eskimo settlement and wipe it out in short order. Now, under modern methods of protection, the native can see for himself the value of the white man's precautions and of the medicines which are sent to him by Indian Health Services. So much in favor is the nursing station that in one district, where one was badly needed, the Indians themselves put up the building, leaving the government to supply only the windows and doors. These people are quite likely to regard their nurse as a minor deity, if they

like her. She will be dealing with conditions that are primitive, where there are no luxuries but where, since no one else has them, they are not missed. Everything in the station is the best of its kind in the way of equipment and furnishings to give the nurses all possible help in doing their work efficiently, but there is no corner drugstore to run to for cosmetics and frills.

She will have that joy of all rural areas—the mail order catalogue. Even the native has taken to this in a big way! Even though he is unable to read the description, he sees the picture and decides that the article advertised will fill a great need in his life, so he puts in his order. Sometimes, the local trader acts as agent for the big mail order houses, despite the fact that they are making inroads into his own business.

Transportation for the nurse runs the gamut of vehicles. One nurse travels her territory on horseback, since there are no roads fit for wheeled traffic; another, on the Alaska Highway, uses a truck of ancient vintage. Canoes, gasoline launches, automobiles, wagons, dog-sleds, even—in case of emergency—the plane, are used for getting to and from her places of call. Although many of the girls enjoy travelling by dog-team, the Department does not encourage this mode of travel except on short emergency trips.

Dress for the northern nurse is different. She usually keeps her hospital uniforms for special occasions, such as visits from officials and doctors and for immunization parades and clinic days. The native regards the clinic as a very special occasion, so the nurse does the occasion honor, too, by wearing her regular hospital uniform. For her visits outside during the summer she usually wears a suit. In the far north, she wears fur garments for which the Department

pays. She selects the pelts at the local trader's, then takes these "dress goods" to the best of the local seamstresses to be made up into slacks, parka, gloves, and mukluks. The outfit is always very becoming and, so garbed, the nurse can face anything the weather has to offer.

For the health centre nurse in the north, a course in public health nursing is an asset, providing she has not specialized too highly, especially in administration. She will need a deep love of her own work and a liking for and understanding of a simple childlike people, whom she can help to better health and living conditions.

Canada's medical aid to the Indian grew out of an "understanding" among the early white settlers that the doctors attached to units of the armed forces would give their services to the native peoples as required. In 1922, an attempt to organize this system was made and several field nurses were appointed. By 1927 the organization had grown somewhat and a very few more had been added to the staff. Today there are 55 field nurses, exclusive of those attached to the Indian hospitals.

A system of radiophones is gradually bringing the nursing stations into direct contact with the nearest doctor in the area or, where the station is not individually equipped, the nurses use the local radio, sometimes that of the local game-warden, the Hudson's Bay Company, or any government project so equipped. By this means, in emergency, the nurses can always summon a doctor or discuss with him any problem that arises.

As the Department adds more and more hospitals, nursing stations and dispensaries, more field nurses will be required. To the girl who likes adventure-with-the-job, there will be plenty of opportunities for those qualified to join the Indian Health Services.

The rate at which births of seventh or higher number of children per family occur has dropped by nearly 60 per cent in the past

30 years, with the decline continuing through the war and post-war years when the birth-rate rocketed.

A Health Survey in the Far North

MARY E. McCANN, B.Sc. N.

Average reading time — 17 min. 24 sec.

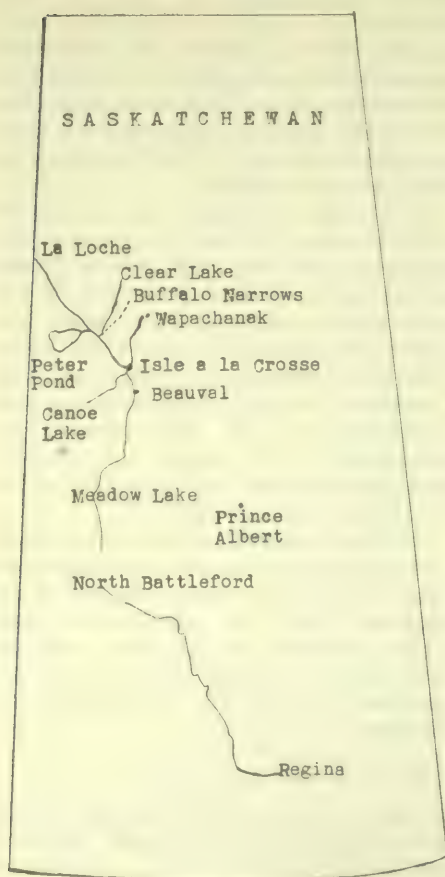
THE PUBLIC HEALTH nurses were responsible for the new step in the diagnosis and treatment of disease among the Indian, Metis, and white population resident in the remote northern areas of Saskatchewan. The health of the Treaty Indians living on the reserves is the responsibility of the Federal Department of Indian Affairs, but the remaining population is the responsibility of the Saskatchewan Department of Public Health. One medical officer stationed in Ile à la Crosse has, for the past three years, devoted his service to this remote and scattered population. He has had the

assistance of a public health nurse stationed in a small hospital at Buffalo Narrows. The nurses in their infrequent visits "out" had reported that syphilis and tuberculosis appeared to be rife among their people. It was at their suggestion that this survey was made.

The joint resources of personnel and equipment of the two departments were pooled and arrangements were made to carry portable x-ray equipment, a portable laboratory for syphilis serology, and a generator to supply the necessary power. In order to test the feasibility of the scheme and to smooth out possible technical difficulties a preliminary survey was made the previous summer when three less remote areas were visited by car. It proved to be workable and, as a result, the survey which we are about to describe was made. The area visited lies in the extreme northwest of the province and it is possible that soon the northeast portion of the province will be surveyed.

The only feasible opportunity for conducting such a survey is at the time of Treaty payments when the Indians and Metis gather and when the travelling facilities of the Department of Indian Affairs are available. It was, therefore, planned that a medical team would accompany the Treaty party in order to take chest x-rays, do smallpox vaccinations on everyone, and to take blood samples for syphilis serology (the Kahn test) on all over the age of 15.

The medical party, consisting of the doctor in charge of Indian Affairs for the province, his secretary for the necessary clerical work, an x-ray technician, two public health nurses, and two laboratory technicians, met



Miss McCann is a staff nurse with the Saskatchewan Department of Public Health

the Treaty party, consisting of the Indian agent and an assistant, at Meadow Lake. A member of the R.C.M.P. also joined us and remained through the entire trip in order to carry, and guard the thousands of dollars of Treaty money. Laboratory equipment had been transported by car as far as Meadow Lake and x-ray equipment by panel truck. There it was all loaded on a freight truck and we were off on the first lap of an arduous but interesting and thoroughly enjoyable adventure. There was a spirit of co-operation everywhere. Throughout the trip it was a source of amazement that a group of people could be so happy under adverse conditions. The work was hard, the hours long, living conditions were extremely primitive, and yet you could not imagine a happier crowd.

The truck ride was almost beyond description. Our first stop was to be at Beauval some 110 miles north of Meadow Lake. The first 30-odd miles to Green Lake were only bumpy but from there on the trail dwindled to nothing. The frequent bumps and boulders almost shook us to pieces and left us breathless. Someone started a sing-song and soon everyone had joined in accompanied by a mouth-organ. Half way we stopped for tea. The men built a fire and we used the laboratory test-tube pail as a teapot.

We arrived in Beauval to find the barge, which was to be our home, anchored in the river. It was the only one of its kind on the lakes, operated by the owner and his 15-year-old son. The top of the barge, measuring about 20' by 10', flaunted a green canvas canopy open at ends and sides. At one end, stairs led to the galley which boasted a long wooden table, wide benches folding back to the wall, an old wood-stove, innumerable shelves, and cartons of food supplies. The barge was pulled by a tiny tug which we soon nicknamed the "Little Toot."

Everyone of our party will always remember the first night on the barge. Apparently only two girls were expected and they were to have had the two bunks on the tug. When five of us and a cook arrived, we had to sleep



The famous barge

in the galley while the men slept up on deck. The mosquitoes were impossible! No amount of repellent seemed effective. Every 15 minutes or so, someone was out of bed making another round with the flit gun. Apparently the men up on deck were having the same difficulty. Finally, they came down to make coffee which we shared gladly. Soon we all decided that sleep that night was out of the question. Shortly after three we rolled up our sleeping-bags and dressed.

We set up our equipment in the old schoolhouse at Beauval. Our supplies were transported by a horse and buggy owned by the local priest. In the entire territory we covered, we received the greatest cooperation from the priests. They had explained previously to the people that everyone—Treaty or non-Treaty—were all welcome and they certainly did turn out. We did not finish until after ten that night, having completed 251 vaccinations, 136 bloods, and about 260 x-rays. The people were most friendly but very few spoke English so we had an interpreter with us at all times.

The chief called the people in by families and cards were filled out for them. The women and girls were shown to a dressing-room where they stripped to the waist and put on gowns in which to be x-rayed. The men merely removed their shirts before stepping up to the machine. Most of them came to the clinic willingly but occasionally a family came who had lived almost completely alone in the

bush and who had seen very few other Indians and no white people. These children were usually terrified. One four-year-old girl required three men to hold her up to the x-ray plate. She was fighting as if her life depended on it—rigid with fear. We had one idea which worked wonderfully well. After a child had been vaccinated he was given a few candies. The parents were very pleased and often the children wanted to come back and be done again just to receive more candy.

That night we refused to try to sleep below again so carried our sleeping-bags up on the top deck with the others where, with a slight breeze, the mosquitoes were not quite so troublesome. About three in the morning we wakened suddenly to find ourselves slowly moving up the Beaver River. We sat up for a while marvelling at the beauty of the country. When we awoke again at almost eight, we were within sight of Ile à la Crosse.

Here again we set things up at the school—this time in a very modern building, the equal of any found down south. A stoneboat and tractor were our means of transporting the equipment to the school where we were soon very busy. By seven that night we had seen well over 200 persons. They have a small but very fine and well-equipped hospital at Ile à la Crosse which is run by the Sisters.



Ready for x-ray and immunization

They were most kind to us, showing us about and answering our many questions. For the most part the Indians appeared to be a cleaner and healthier group than those found on most of the southern reserves close to the white man. Heads were clean, there was little evidence of skin disease, and the clothing was all fairly new. We were told that when clothing wore into holes it was seldom patched but discarded and new garments purchased. The one lasting feature of the Indian's dress is his moccasins. Men, women, children, and small babies all came wearing beautifully beaded moccasins. In the majority of cases rubbers were worn over these to protect them.

It was decided that we should leave at about eight for Buffalo Narrows where we were to work the next day. The Indian agent and his assistant had planned to go by canoe and offered to take one of us along, expecting we would be there long before the barge arrived. I was the lucky one and after a short delay, including picking up 250 pounds of nails at the Hudson's Bay Company store, we started up Deep River. It was a grand trip but toward eleven o'clock the skies became very dark and there was lightning close by. Finally about midnight it began to pour. Although I had a ground sheet around me, I was drenched. The river too became very rough and we were forced to pull in to shore. In that uninhabited country we were more than lucky in finding an old deserted shack. The roof leaked in places but we laid our sleeping-bags on the floor amid the clutter of broken bottles, old rusty tin cans, filthy newspapers, straw and mice and soon were sound asleep. The sun shining through the window wakened us in the morning. After a wash in the river we went on to Buffalo Narrows. We found the barge (which had also been forced to anchor near the shore until the storm was over) had just arrived.

All Wednesday we worked at the small, bright school at Buffalo Narrows. Next door was a tiny but lovely hospital run by one of our public health nurses. She went out of her

way to assist us with our work and to extend to us that very much appreciated northern hospitality. During the day we had a little excitement. One of the boys accidentally dropped a lighted match in the waste basket where I was throwing ether sponges used in the vaccinations. The resulting blaze spread and by the time we had stamped out the flames I had burned the stitching on my shoes and was forced to wear my slippers until I had a pair of moccasins made. By night we were not finished but since our plane was coming in the morning to take us to La Loche, we promised to return and complete the work on Saturday.

Thursday morning we flew to La Loche on Methy Lake. This was our one plane trip, taking over an hour, but it was apparently the only way into the outpost. We again worked in the tiny school, met with wonderful hospitality, and the people turned out well. We were all very impressed by the way in which the Indians, most of whom had travelled long distances with large families, set up their tents and then very patiently awaited our arrival. There is no hurry or commotion such as one sees in the cities. Time means nothing to these people. Everywhere we stopped we noticed that no activity could be seen anywhere until 11:00 a.m. There seems to be no morning at all.

Several things impressed us about the Indians. The most outstanding thing was the rapidity with which they seemed to have aged—young people of 20 looked 30, people of 45 looked 60. One could understand when one saw a 15-year-old married girl come in with one or two children, and this is common. The hardships of living and the lack of all modern conveniences would probably be a great factor, too. One modern invention they nearly all appeared to have was a motor for their canoes; paddles appear to be becoming obsolete.

That night we girls slept in a bed—the only bed in three weeks. Some of the Sisters at the four-bed hospital were on holidays and accommodation

had been arranged for us there. The men were not so fortunate—they slept on the schoolroom floor.

The following morning we completed our work and, while waiting for the plane to arrive for us, we walked about visiting Indian tents and attempting to carry on some kind of conversation with the people. We also watched the workmen constructing the new hospital, a welcome addition to the present small one. The Sisters are doing outstanding work, particularly in attempting to admit maternity patients for a 10-day period. During this time, with the excellent care they receive, the women are bound to gain some knowledge which they will take home with them and, as best they can, put into practice. The priest spent some time telling us of his people.

Saturday, as planned, we completed our work at Buffalo Narrows and were pleasantly surprised by an invitation from the public health nurse to a chicken dinner and, later in the evening, a weiner roast at McKay Island, a short distance by boat. We were always pleased when we could get away from the wharf at Buffalo Narrows as there is a large fish packing plant and the smell was most unpleasant. With the mouth-organ, our lusty voices, and lots of weiners we had a wonderful time on the island.

Sunday about noon we left for Peter Pond Lake. About two o'clock our skipper decided it was too rough to enter the large lake so we pulled into a cove and spent the afternoon. In the shelter it was warm, calm, and peaceful. We swam and, as there was a beautiful sandy beach, most of us tried to secure a tan. We went fishing and before long we all had a pile of fish beside us. They were mostly pickerel and just begging to be caught. After a supper of delicious fried fish, we left for Peter Pond. About nine that night we anchored a mile from the settlement called Dillon.

Early on Monday morning we walked along the wet sandy shore to the outpost. There was no school or hospital so it was decided that we would use the Chief's house. He is



We go fishing

Chief of the Chipewyan band, although a large number of the people we worked with were Cree. The languages are so different it is completely impossible for one to understand the other.

Tuesday was spent in travelling to Clear Lake where we arrived in the late afternoon. It was another beautiful day and a lovely trip. It is somewhat difficult to say whether the country is one great piece of land with a million lakes or thousands of islands in one large body of water. This was noticeable particularly from the air. At Clear Lake we found we were to work in the Chief's house but would not begin until the next morning. They were building a new church at Clear Lake. The priest told us that when the old one had burned a year ago, all that was saved was the big church bell. He rang it for us and it was still clear and perfectly toned.

The next morning we found things were going to be very crowded. The x-ray equipment was put in the small house and the doctors made their examinations there. Outside on the porch the nurses had their tables and equipment for vaccinating and taking bloods while on the other side the two technicians set up their laboratory. All day we had quite an audience of curious Indian children who appeared fascinated by the procedure. When the people had gone through the clinic,

the Treaty Indians went down to the barge to receive the Treaty. Here I attended my only band meeting. Apparently, after all the Treaty has been given out, the Chief, councillors, and as many of the band as wish, meet with the Indian agent to discuss their wants and problems and to voice any complaints. One would be surprised how greatly these people's problems resemble our own.

Wapachanak was our next stop. It was necessary for us to portage about a mile from our anchorage, due to a series of rapids which could not be attempted by barge. The walk was lovely and served to create an appetite. Our first day working here was so hot that several Indians fainted and it was necessary to continue the following day. This delay caused us to run into bad weather. We were forced to remain anchored until Monday.

When we returned to Ille à la Crosse there was only one more trip left for us but it proved to be the most interesting. We were to go up Canoe River to Canoe Lake one day, spend the next day working, and return the following day. Canoe River is aptly named as it is so shallow and full of rocks that only an experienced guide with his canoe could find the way. The supplies were transferred from our barge into nine canoes, each with its guides hired for the trip. Two of us were alone in one of the smaller canoes which had just one Indian. Before we had gone very far we came to some rapids up which it was necessary to pole. Our Indian was having a great deal of difficulty making progress so finally he turned to us, handed each a paddle, and said, "Work." We worked, much to the amusement of the people in the other canoes. At the first opportunity a re-arrangement was made so we had at least two men in all the canoes.

It was a beautiful sight watching the canoes winding in and out among the rocks and rapids following almost exactly in the course of the first canoe whose guide knew the river well. On one occasion it was necessary for us to get out and portage while

the Indians took the canoes up a long stretch of especially treacherous rapids. The portage was through thick brush and we sank in muskeg up to our knees. Being so damp, the mosquitoes were out in full force and we had to carry branches to keep them away. After a short distance the muskeg dried and we were forced to put our shoes on and roll down our slacks to prevent the dry branches and twigs from scratching our legs. At the end of the portage we made a smudge and sat down to wait for the canoes.

After 12 hours' travelling we arrived at Canoe Lake and found refuge in the small house belonging to the priest who was away at that time. While some slept in the tent pitched by the Mountie, the rest of us spread sleeping-bags on the floor. Being accustomed to such a hard mattress by this time, we slept very well.

We were all beginning to feel that the trip was just about over by now. We returned to Ile à la Crosse and continued by barge to Beauval where we spent the afternoon at the Indian Residential School. As the Indians on the reserves become acquainted with the advantages of having their children attend the school, more and more are being sent yearly until now they have 150 boys and girls. Schooling is not compulsory for them. The school, with a priest as principal and a number of Sisters and Brothers to help him in his work, is completely self-supporting. It was built of bricks which were made on the grounds. They have their own power-house, carpentry shop, machine and welding shop, sawmill and lumber yard, and a farm complete with stock. For the girls there are sewing-machines and



Poling upstream

even looms where they weave the cloth with which they make clothing for themselves. Each yearly holiday time the children are sent home with a new set of clothing they have made personally. One would think it impossible for these Indian children, after receiving several years of such fine education, to return to the reserve and fall into the backward and often unhealthful habits of their people. Yet many do seemingly forget all they have learned.

The following morning our truck was waiting for us. We climbed in wearily, loaded our equipment for the last time, and somehow survived the long and even rougher ride back to Meadow Lake. The soft hotel beds felt good but most of us had to put our blankets off the bed onto the floor before we could sleep.

Altogether we completed over 2,300 x-rays, about 2,200 vaccinations, and some 1,220 bloods. The results have been most enlightening and it is felt that if such a survey can be continued from year to year, followed by necessary treatment, we will soon have both the tuberculosis and venereal disease rate under excellent control in far northern Saskatchewan.

The efficiency of a physical therapy department may be seriously impaired by having the available time and space for treatment monopolized by old cases which have passed a point where specific benefit may be expected but whose orders have not been changed by the attending physician. This causes unnecessary expense to the institution or patient, or both, and interferes

with the effective treatment of other cases. It is as important to know just when to terminate or make a transition in physical therapy as it is to know just when to prescribe it. For example, after a fracture the prolonged use of heat without making a transition to contrast applications (cold, massage, etc.) leads to passive congestion, followed by chronic swelling and thickening.

Highlights of Treaty at Oxford House

JOAN EDWARDS

Average reading time — 5 min. 48 sec.

ABOUT the second week in June, the Indians started arriving from their winter camps to attend the treaty. Almost overnight a tiny village of tents sprang up. The ones owning homes started cleaning up their yards to a noticeable degree. New dresses were purchased by the women and girls, and gaudy shirts and wind-breakers by the men and boys. A few went so far as to get their hair cut! All was in readiness.

At treaty this year the Indians were fairly well dressed. In fact, one of the medical party commented on how clean the Oxford House Indians were and how nice their clothes appeared to be. That was true but the sad part is, in the majority of cases, the new clothes are all that they have and will be worn, sometimes without change, until next treaty. A few days before treaty the family allowance cheques came in and with this money the new things were purchased. If it had not been for these cheques many would have been in rags.

At this time, too, they were fairly well fed as fish and ducks were plentiful and the Indian diet was augmented by the occasional moose. One Indian does not keep a moose for himself and family but shares it with all his friends and neighbors. Thus the majority had a taste at least.

The plan at each treaty is that the people must have their x-rays and inoculations first and then collect their treaty money. This has been the custom ever since the medical group accompanied the treaty party for the first time. The Indians understand this arrangement and make no fuss about being x-rayed and inoculated. This year a health talk was given by the doctor and one of the x-ray

technicians in front of the chief and councillors. The talk was enthusiastically received and made a big impression. X-ray plates were shown to those in attendance and their meaning explained in simple terms.

On the first morning of the treaty, the medical party went by canoe from the nursing station and landed near the United Church, where the x-ray equipment had been set up in readiness the night before. Although there did not seem to be many people around when we first arrived, within a few minutes the door-way of the church was crowded. The first few families were x-rayed and inoculated with combined diphtheria and pertussis vaccine within a very short time. The doctor examined them as they passed. Any needing teeth extracted received attention. Some with boils were given penicillin in oil, etc.

The head of each family received a slip of paper upon which was written the number of members of his family. This he took with his treaty card to the Indian agent who had his headquarters in the Council House. There, with an R.C.M.P. standing by in his impressive uniform, each Indian received crisp new dollar bills in the amount specified by the size of his family. The satisfied grins at this point were many.

Back in the church the work went on, while little noses were pressed in fascinated interest against the window-panes. In the churchyard we could see whole families sitting around on the grass, waiting for some of the congestion to ease away from the door. Then they in turn entered and had their x-rays, etc. Even after the different families had received their treaty money, they came back and sat around watching the remainder go into the church.

By noon on Monday, July 4, all x-rays had been taken and inoculations

Mrs. Edwards is field nurse at Oxford House, Manitoba, under the Federal Indian Health Service.



Whole families sat and waited their turn.

given. There had been 433 persons (including seven whites) x-rayed, 276 inoculated.

In the afternoon, B.C.G. vaccine was given to 84 Oxford House children and three non-treaty children. This was something new to these Indians. They submitted quite willingly and, in general, seemed to understand that they would benefit by it. Of course, being very superstitious, they didn't speak of it as vaccine. The B.C.G. is, to the Oxford House Indian, "strong, white man's medicine" and they let it go at that. Several times I heard the remark passed "musko-a muskeekkee" (strong medicine) in reference to the B.C.G.

After the treaty party left, a dance was held at one of the homes and nearly every young Indian on the reserve attended. They do the old-fashioned square dance chiefly. Oddly enough the dances are all "called" in English.

Next evening canoe races were held. During the afternoon "the plate was passed" and donations from ten cents to five dollars were received for prize money. The races were to start at eight o'clock and crowds gathered along the shore to watch. The first race required that three men be in each canoe—one at the stern and one at the bow with paddles, one in the

centre with oars. The oarlocks are very unusual, being primitively fashioned from tree branches and nailed to the side of the gunwale. The oars themselves are nearly all home-made.

If it had been young white men in the race, practice runs would have been held for days or weeks in advance and the canoes would have been checked and rechecked hours before the races. Not so with the Indians. After much urging and coaxing two canoes with the necessary crews went to the starting line. Two were not enough for a good race so one of the white men went about coaxing others to enter. Finally, one of the canoes at the starting line turned and went back to the shore. The Indians got out and started pounding the oarlocks tighter, removing cross-bars, and otherwise giving the craft a going over. Then the other turned back and the same thing happened. The crews were shuffled about and bedlam reigned.

We were almost giving up hope of having a race when they announced they were ready. By this time it was nearing sunset. However, four canoes floated up to the starting line. Then a canoe with an outboard motor went to a point about two miles out in the lake. The canoes were to round this spot and return to the starting line.



The old lady has the most beautiful smile at Oxford House. The young woman holding baby is 17-year-old mother who won women's boat race.

At the word "Go" the paddles flew and the water churned. They made the four-mile round trip in approximately 10 minutes. Near the finishing line an oarlock broke on one of the boats but the contender made a magnificent effort to keep in the race. To thundering cheers the first canoe swished across the finishing line, a few inches ahead of the others. The flushed victors received the prize money and the applause of the spectators.

Next, a race of the same type was held for women. They didn't make one quarter the fuss that the men had made. Six canoes were entered. A tall, handsome old lady of 60 was at the oars in one canoe and we were all cheering for her. The "rounding point" was moved in a little closer and within minutes the race was on. It was very good. However, our fine old lady was beaten by a 17-year-old mother.

Two amusing races were held next. In the first, one person was in the bow

of each canoe. It is so easy to lose control in this case. The canoes would swing around and bang each other. In fact, this hindrance was apparently part of the game. The ones that fell behind at the beginning of the race attempted to bunt the winning canoes as they returned and put them out of the race, too. I was watching the women's race through field-glasses and was astounded to see, in one of the canoes, a mother who ten days before had been delivered of a son. I was a little worried about her but she was laughing and shouting with the rest. No harm was done as she was the first to drop out of the race when she lost control of her canoe. She paddled back to shore before her friends started bunting the canoes which had rounded the half-way mark. But imagine a white woman entering a canoe race under the circumstances!

After the canoe races the crowd moved to the field behind the Hudson's Bay post and there foot-races were held for the young folk. This was followed by a "candy kiss throw" for the little ones. What a mad scramble that was!

At 10:30 p.m. the day was wound up with a football game between the Indians and the whites. Considering that none of the latter had played football in years, they did very well against the Indian youths who practise all throughout the long summer evenings. We were defeated two to one.

Everyone went home, as the old saying goes, "tired but happy" at midnight. Streaks of pink were still visible in the twilight sky. Treaty time was over for another year.

Picnic Package

The success of a picnic depends largely on the food that is taken along. A day in the out-of-doors sharpens appetites and makes meal-time an important event. Fresh vegetables can be kept crisp and moist by packing

them in a covered glass jar, plastic bag, or waxed paper. Some standard picnic items that always help fill the bill include hard-boiled eggs, cheese, tomatoes, lettuce, celery, and fruits.

It is because nations tend to stupidity and baseness that mankind moves so slowly; it

is because individuals have a capacity for better things that it moves at all.

—GEORGE GISSING

The Nurse and the Law

CARL LEDOUX

(Conclusion)

IN CRIMINAL INVESTIGATION it is the detail which counts. The efficient detective officer must have a fully developed sense of observation, some imagination, a logical well-ordered mind, good general knowledge, a fund of experience upon which to draw, and a painstaking thoroughness which does not take into account the time and labor spent, but only the solution of the problem in hand.

He must be devoid of preconceived ideas or "hunches" and capable of long hours of fruitless effort without being discouraged. The brilliant detective, who can solve the most complex problem in a dramatic radio murder story within the allotted half-hour program, is, as his role implies, merely a figment of the script writer's imagination.

Perhaps I might add a few more remarks relative to post-mortem procedure. It is most desirable that a sample of the deceased's blood be taken for "grouping." This is necessary in the event we may later find a suspect with blood-stained garments. Should the blood be of a different group to the suspect's, but of similar group or type as the victim's, the fact would be of considerable value in evidence. If the victim has not been "grouped," and the body is embalmed and interred, we have no direct method of getting this information, unless of course he had a transfusion before death overtook him or there is some other authentic record.

For similar reasons we would also like to preserve a small tuft of the deceased's hair. During investigation, a blood-stained stick or bludgeon with a few hairs adhering to it may be found. It will then be necessary to have a comparison made with the deceased's hair through microscopic examination.

In cases of death by drowning,

a technique has been worked out by Dr. Gettler, chief medical examiner for the city of New York, which determines whether the victim actually drowned. In New York there are numerous instances of gangland murder where the victim's body is disposed of in the Hudson or the East River. For the proper investigation of the case, it is necessary to determine whether the victim actually drowned or was dead before immersion. Dr. Gettler's technique determines whether the victim was breathing at the time of submersion. The theory is that a person who is still breathing when immersed will inhale quantities of water. There will be a dilution of blood in the left side of the heart and, if the drowning occurred in fresh water, the chloride content of the blood in the left side of the heart will be lower than that in the right side. Conversely, if the drowning occurred in salt water, the additional chlorides in the sea water will increase the left heart blood chloride content over that of the right side. Should both sides of the heart have the same content, it is reasoned that the victim did not inhale water at the time of immersion. This test is more indicative than conclusive. Dr. Alan R. Moritz, professor in the Department of Legal Medicine of Harvard University, has done some further research in this connection and utilizes the magnesium content of the blood as a more critical indicator, as well as the chlorides.

The identification of the dead frequently presents monumental obstacles. We rely, of course, a great deal on finger-prints. Where the identity of a body is in any doubt, post-mortem finger-prints are taken which are later compared with existing records, both in our own Finger-print Section at headquarters and in those of the national capitals at Ottawa

and Washington, D.C. During the war, many people were finger-printed for security reasons who had never been convicted of any offence. These records are naturally kept entirely apart from the criminal ones, but are available for the identification of the dead, if necessary, and are invaluable in tracing victims of amnesia and others who may have temporarily lost the use of their faculties.

Of course many people have never been finger-printed so other means of identification have to be used. Accurate descriptions are taken, showing apparent age, both from appearance and from autopsy, height, weight, color of hair and of eyes, birth-marks, scars and deformities. Operative scars are often of great value and x-rays reveal old fractures which will help in making an identification. Photographs of the deceased are taken but, more often than not, these are of doubtful value due to post-mortem changes and other conditions which alter the appearance of the dead. The recent fad for tattooing is of some assistance, though not too reliable. The same design is used over and over again on many people and so cannot be considered as conclusive without other supporting identification.

One of the most effective methods of identification is through dentures. In cases where the victim has been rendered unrecognizable through decomposition or where he has been the victim of a conflagration, the denture is often the only means of identification. An examination of the deceased by an experienced dentist will often supply a great deal of information concerning the unknown. A plan or chart of the mouth is prepared, showing extractions, fillings, and other repair work, with notations on how long before death the work was performed. Information of this kind circulated among members of the dental profession has at times brought excellent results. Most dentists keep a chart of their patient's dentures and can usually recognize their own work. It is very rare for two persons to have the same dental plan involv-

ing extractions and repair work. Materials used for repair are also an indication, such as gold fillings, amalgam, and so on.

Chronic organic disorders concerning which the deceased must have consulted a physician during life are also valuable in circularizing the profession.

Any label or tag, as well as cleaner's and laundry marks found in the clothing of the unidentified dead, are traced through trade organizations. In fact every possible channel of inquiry is probed in an endeavor to ascertain the identity of the deceased, which includes a perusal of all files of missing and lost persons covering an appropriate period.

Occasionally a patient is brought to the hospital in a dying condition and, before he passes away, makes a statement concerning the cause of his death. This statement may be invaluable to the investigation and presentation of a criminal case. However, not all dying statements are admissible in court and we should, therefore, examine the requisite elements. An ante-mortem statement will only be admitted in a charge dealing with the death of the person making the statement. He could not, for instance, make an admissible statement concerning a robbery he witnessed if he were dying, say, of pneumonia.

The next ingredient is that the person making the statement must have a positive and hopeless expectation of imminent death and that this information shall have been imparted to him by a person with authority, usually a doctor. The statement can only include admissible evidence—that is to say, evidence which the person would be permitted to give if he were actually in court himself. This naturally excludes from the dying declaration any hearsay evidence and so forth.

The statement should be taken preferably before a justice summoned to the death-bed for this purpose, but if there is no time the doctor or nurse is justified in taking it. A notation should be made of the time, date,

place, the number of persons present and who they were, and what information was given the deceased touching his condition before he made the statement. All this will be required when the Court is asked to admit the evidence. The statement should be written out as nearly as possible in the words of the dying person and, if he is able, he should be asked to sign it. Witnesses will also mark the written record in such a way that they will later be able to identify it, usually by signature. The theory upon which a dying declaration is admitted in evidence is that a person about to die, with no possible hope of recovery, will tell the truth before expiring.

In the case of a woman dying as a result of criminal interference with a pregnancy, who makes a statement before she passes away implicating the abortionist, the statement could *not* be used on a charge of abortion against the culprit but, if the conditions previously mentioned have been met, it *could* be used on a charge of murder or manslaughter. The culprit would usually be charged with murder.

In the public interest, it is very necessary that those charged with the enforcement of the law be given every possible assistance in tracing and prosecuting the many unscrupulous, callous, and inefficient individuals who practise their nefarious trade on the worried and ignorant expectant mothers. In some quarters there appears to be a friendly feeling towards these harpies of a restless civilization. They are endowed with an aura of beneficence. Young women speak of being "helped out" by Mrs. So-and-so, but the help they receive is always for a cash consideration—a consideration which may even cost them their lives. The abortionist is usually an untutored and reckless person who knows that, while the physician spurns their dirty work, he will not stand idly by if the unhappy victim of their interference develops septicemia and has to be admitted to hospital. Should the worst happen and the patient die, the cul-

priet relies on the secrecy of those concerned and on the victim's mistaken sense of honor. Any help you can render in putting the abortionist out of business will be a valuable contribution to the community's well-being.

Before I close, I would like to add one more point in the matter of statements. Under our law, if a woman is the victim of a sexual assault, evidence may be introduced concerning her first report of the attack and what she said at the time. It is necessary, however, that the statement shall have been made at the first available opportunity. A delay of a day or perhaps of several hours may render the statement inadmissible if the victim had the opportunity of reporting the occurrence before that time. The theory on which the statement is admitted is not to corroborate the *truth* of her allegation but rather to show that her first statement, made at a time when the events were still fresh in her mind, is consistent with the story she later tells in court. Actually it is a test of the demeanor of the ravished woman immediately after her assault.

It is quite possible that some day any one of you may be in the position of receiving such a complaint or statement. In that event, you should remember to note the time, place, date, and the physical condition of the girl when she first came to your notice. Particular attention should be given to the condition of her clothing, whether she still has her shoes on and so forth. In fact anything of an abnormal nature should be noted. The statement should be taken down as closely as possible in her own words. It is not necessary that there should be another witness to a statement of this kind.

I will close with this one thought. A single paper match, torn from an ordinary match booklet, may be the one piece of evidence placed on the scales of justice which will tip the balance and convict an enemy of society—your enemy. Will you help us fight that enemy?

The Teddy-bear was named after Theodore Roosevelt because he had a small bear as a pet.

Aims of Professional Education

MARY E. HENDERSON

Average reading time — 8 min. 6 sec.

PROFESSIONAL EDUCATION is rather an indefinite, abstract subject, and one in the development of which many profound theories could be presented. However, my approach will be very simple, clear, and straightforward. In order to treat this subject at all satisfactorily, we should agree on what we mean by a profession. There used to be just three learned professions—*theology, law, and medicine*. Of these, *medicine*, in spite of the fact that there were great physicians in ancient times, has come into its own only comparatively recently. Today, there are many other professions to be added—*dentistry, engineering, social work, teaching, and nursing*, and perhaps others may be added to the list.

The definition of the term "profession" has been attempted many times and seems to be a point of some difficulty. The definition given by Dr. Cottrell, dean of the College of Education of Ohio State University, seems to be as simple and clear as any other. It reads:

A profession is a voluntary association of people devoted to the promotion of human welfare through the practice of an art based upon scientific skill and understanding. Professions come into being through the efforts of the members of an occupation to build their work upon a firm foundation of expertness and to see to it that their common effort benefits society.

Let us analyze what is implied in this definition.

First, a profession is an occupation which aims at *some benefit to society*. The professional worker must care about human welfare in his work. Each profession has an important social task to perform which contributes directly to the common welfare.

Miss Henderson is educational supervisor with the Metropolitan Health Committee, Vancouver.

Candidates for a profession, it naturally follows, should be persons of high moral purpose and of unselfish aims.

A second implication of the definition, and the one regarded as the most distinctive and essential characteristic of a profession, is that it depends for its practice upon a *well-organized body of scientific knowledge*. Although a profession is a practical occupation, it cannot be carried on without a knowledge of scientific principles and theory, obtained usually in a professional school or university under competent instructors. The professional worker must have skills but these skills must be combined with and rest upon theoretical knowledge of scientific principles.

The members of a profession are chiefly responsible for the *standards* of their profession. Through their professional associations, standards of efficiency, as well as the social status and the material prosperity of members, are maintained and raised.

Let us relate these attributes of a profession to our own field of nursing. We can truthfully say that nursing has an important social task to perform which contributes to the promotion of human welfare. Nursing may be said to be an art based on scientific skill and understanding. Nursing associations are very interested in maintaining and raising their standards—in protecting their members and giving a high standard of service to the public. In all these respects, nursing meets the requirements of a profession.

Nursing is a very new profession—it has been called an emerging profession by educationalists. Some of the respects in which it lags in comparison with other professions will come to light if we consider the evolution of professional education. Samuel Capen¹, a noted American educationist, described four cycles through

which professional education has passed. The first was the cycle of apprenticeship. For a time the apprenticeship system proved effective but, generally speaking, it failed in producing the quality and quantity of required professional workers. We must admit that to some extent nursing is still partly in this stage—certainly more than all of the other professions mentioned.

The second is described as the cycle of expansion when professional schools sprang up to supplement apprenticeship. Often they were inadequately equipped and imposed no educational requirements on the students.

The third cycle was one of regulation and standardization, with the educational institutions and professional associations setting up standards and obtaining governmental authority for enforcing them.

The fourth cycle Mr. Capen describes as the cycle of critical analysis in which there is analysis of professional activities, standards of practice and education. In Mr. Capen's opinion, nursing is going through all these cycles at the same time. Today, it can be said that nursing leaders are everywhere carrying on an analysis of education for the different fields of nursing and of the needs of present-day society for types of nursing service. They are also considering the rewards and satisfactions of the student and graduate nurse.

General educational requirements for entrance to professional schools is another point which should be mentioned. Educationalists consider the fundamental task of general education is to produce well-balanced students, ready to take a significant, useful place in society. The expression "Education is the key to an abundant life" has been used. It is universally accepted that a good general education should precede professional education. In this instance again, we must admit that educational standards for entrance to nursing schools are below the level of those of other professional schools. Most professional schools require at least two years of university education before

entrance to their own schools or their preparation is received entirely at university level. There still are instances in nursing of where educational standards are below high school graduation.

Up to this point, we have spoken of the meaning of the term "profession" and all its implications and of the evolution of professional education. With these remarks as a basis, let us now turn more closely to the heart of our topic. Dr. Cottrell, also sets out the three principal obligations of professional education. They are:

1. To provide a supply of workers at a defensible level of competency to meet the reasonable requirements of society for the popular service.
2. To guarantee the technical, scientific, and artistic proficiency of all practitioners above a determined minimum.
3. To lay a basis for and to foster the emergence of leadership among all practitioners, both in the improvement of the practice of the profession itself and in bringing the special contribution of the profession to bear upon the general social situation of the time.

To reduce these to very simple terms, we may say that the main aim of professional education is to produce an adequate supply of competent scientific workers to meet the needs of society. Professional education should foster qualities of leadership so that the necessary numbers of professional members will accept leadership and work towards maintaining and improving their professional standards and assuring that the needs of society are met. With these aims we would all agree.

To consider further the question of maintaining an adequate supply of professional workers, we know from experience in the nursing field that this is a very difficult problem. Among other things, it entails a careful estimation of overall needs and recruitment of a sufficient number of desirable candidates. At one time the supply of nursing students was left entirely to chance, but in recent years an endeavor has been made to encourage recruitment and

to expand schools of nursing more in line with the needs. We all know something of the efforts of our national and provincial associations in the student recruitment program and in raising standards of nursing schools. Certainly we realize, too, that all types of professional education have too vital a connection with the public welfare to be left completely unplanned and unregulated. The distribution of workers according to needs, in urban and rural areas is another difficult matter. Unequal distribution of doctors, nurses, and teachers in these areas has long been a serious problem.

Professional associations are alive to all these problems and are endeavoring to work towards solving

them. An encouraging fact is that we can say today that the government and our citizens generally are taking a far keener interest in all these questions and are uniting with the members of the professions in demanding expansion and betterment of all public welfare services.

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In the Good Old Days

(*The Canadian Nurse*, August 1910)

"The medical inspection of schools is of very ancient date; the Egyptians and Grecians had teachers skilled in the art of curing, who looked after their pupils. Then we hear very little of it until 1842, when the laws of Paris ordered that all the public schools should be visited by a physician, who would inspect the school children and the buildings. . . . In 1894 the London County Council had nurses visit their schools and take care of any minor contagious diseases among the children. . . . That same year, Boston appointed medical inspectors, who inspected the schools regularly. In 1895 the program was introduced in Chicago. In New York, it was brought about by an epidemic of scarlet fever which was caused by a small boy pulling pieces of skin from his hands and passing them to his playmates."

* * *

"There are as many different kinds of nurses as there are kinds of people—everyone has a different nature. The first essential of being a good nurse is to be a womanly woman. The reason we hear of indifferent nurses is that, as a band of women, we stand or fall together. If one nurse is found indifferent to the claims of her profession, we are all

criticized and put down to that same level."

* * *

At a special meeting held in Toronto on May 25, 1910, Miss M. A. Snively moved "that this meeting of representatives of the combined associations of trained nurses do hereby resolve that there be formed and organized the Canadian Branch of the Army Nursing Reserve."

* * *

"Vancouver is preparing plans for an isolation hospital, to cost not less than \$20,000."

* * *

"In April, the graduate staff of the Montreal General Hospital gave a 'weighing party,' the proceeds to form a nucleus for a Sick Benefit Fund. The party was a great success and over \$300 was realized."

* * *

"Last year (1909) carefully prepared regulations were issued and each hospital for the insane in Ontario, to which acute cases are admitted, was required to establish a Training School for Nurses. A three years' course of study was decided upon so that at each institution a uniform system of instruction would be followed."

Washing Windows — Use up-and-down strokes for the outside of the window-pane and side-to-side strokes for the inside. Then, if a mark is left, it is quite simple to tell which side needs the additional shining.

Public Health Nursing

Developing the Social and Health Aspects of Nursing

IRENE LAWSON

Average reading time — 4 min. 48 sec.

Note: The W. K. Kellogg Foundation offers scholarships to certain Canadian universities to assist in preparing faculty in schools of nursing. Miss Irene Lawson, assistant superintendent of the Victorian Order of Nurses in Hamilton, was granted such a fellowship to assist her in strengthening the public health field experience offered in the community to the students of the McMaster University School of Nursing.

* * *

The following are two excerpts from the report written in connection with my three-month travel fellowship. The first is the summary of an interview with Miss Margaret Scanlon, senior supervisor, State Board of Nurse Examiners, New York. This gives some guidance as to how public health nursing personnel can be used in schools of nursing:

The State of New York considers it essential for all schools of nursing, within the state, to emphasize the social and health aspects of nursing in the student program. To meet this need some schools are employing public health coordinators, while others are depending upon present staff to carry out these principles. To assist in this project the State Board of Nurse Examiners has added Miss Scanlon to its staff. The purpose of her appointment is to provide assistance in clarifying and developing the function of health personnel in schools of nursing.

Miss Scanlon discussed the role of the health coordinator, beginning with her early experience as a coordinator when hospitals did not understand the scope or complete value of this addition to their staff, realizing only that it was a step in the right direction to employ such a per-

son. In defining her later findings, she implied that the health teacher must occupy a position comparable with the associate or assistant director of nurses, with equal requirements for qualification and equal salary. To assume an adequate role the health coordinator needs the authority this status provides. She needs a voice in policy-making in order to direct the thinking of personnel in the fields of both education and service. She needs to act as a resource person and to be available to all members of the staff and faculty for resource purposes in order to develop an awareness of positive health that will permeate the whole group responsible for the education of nursing students. She should have opportunity to observe existing policies and have time for developing research.

Effective use of the coordinator must carry the complete understanding of all groups from the hospital administrator downwards. She must have the understanding of the medical profession, the hospital social service, and the outpatient department, where two-way referral systems link the patient and the hospital with the community and the home. Miss Scanlon sees "individual patient care" reaching its full value only when a health consciousness is reached that envelopes both student education and patient service and embraces all hospital departments.

The second excerpt is an account of a case study which was presented by the students of the Department of Nursing of Skidmore College, under the direction of Miss Irene Carn, at an institute for teachers held at Teachers College, Columbia University, on "The Social and Health

Aspects of Nursing in Schools of Nursing." We feel this patient-centred conference is an excellent method of developing the concept of total patient care:

Objectives of this method:

To develop within the student an appreciation of the patient as a person or individual, with family ties and community relationships.

To help the student apply and integrate what she knows of the health and social aspects of nursing.

Mechanics of this method:

The instructor contacts the ward a few hours previous to the conference and delegates one student to bring a case history of a patient for whom she is caring. The student chooses a patient known to the various members of the group, if possible.

The group consists of nurses from the same ward but not necessarily the same year, hence students may be juniors just learning this method or seniors well practised in it. No preparation is considered necessary other than the good day-by-day nursing care that each student is supposed to be giving her patients.

The student selected presents her case history to the group. Another student is asked to lead the discussion.

All students participate in the discussion, bringing to light considerable information gleaned from the patient and his family by the various nurses caring for the patient.

The instructor's role is passive and control is released to the students as soon as the introduction is completed. Assistance, however, may be given the leader in drawing in timid students.

At the close of the conference the narrator is asked to bring a progress report to the next class.

SUMMARY OF CASE PRESENTED

The case history presented was that of a child of three years suffering from eczema. The students discussed the known family aspects and personality traits of the child. They related the present condition to previous attacks, and present care to what the mother might be expected to know and carry out safely. They then drew up a plan whereby the mother would spend a morning at the hospital observing the nursing care and

treatment of the malady. The mother would be asked to return a second day to give the care to the child under the guidance of a nurse.

A plan was set up to contact the visiting nurse association for supervision in the home; to contact the doctor for dismissal of the patient and orders for the V.N.A.; to contact the nutritionist to interview the mother; and to contact the out-patient department for a return appointment for the child. A memo would be posted on the ward regarding this appointment so that a student might see the child at this time. It was felt that guidance should be sought in the community, possibly through parent education classes, to enable the mother to better understand the personality problems of the child handicapped by recurrent illness.

Evaluation of this method:

1. The focus is centred upon the patient as the primary source of information.

2. The currency of a case is the satisfaction to the student.

3. The student relates one fact with another within the case and recognizes the relative importance of the collection of facts as considered by the group.

4. The student begins to apply and integrate what she knows of the health and social aspects from any source—her home, her life, her lectures, and good basic knowledge.

5. The student begins to relate this experience to good nursing care and learns to formulate a plan of care for each patient.

6. Student growth is promoted to a degree that warrants the use of valuable time in this type of learning situation. The student develops:

- (a) a widened point of view;
- (b) a capacity for recall, comparison, and judgment;
- (c) an ability to present material and express herself orally;
- (d) an ability to think constructively and objectively through group participation;
- (e) a greater confidence in herself.

7. The rapport established by the faculty and students, thinking and planning together, has definite value in student development.

Hidden Diabetes with Psychosis

CHRISTINE MACLEOD

Average reading time — 5 min. 36 sec.

MR. ABEL, a postal clerk, aged 59, awoke July 3 feeling that something was terribly wrong! As he expressed it later during his convalescence, "I couldn't think." His wife said he went into a sort of coma. By noon he was muttering incoherently, making useless motions with his arms, and while still in a comatose condition his family physician sent him to hospital to be under the care of a neuropsychiatrist. Preliminary diagnosis on admission was: (1) manic-depressive psychosis; (2) pre-senile arteriosclerosis.

His condition was poor. He was uncooperative, incoherent, resistive, even violent at times, refusing all food and fluids. Blood pressure (116/90) was normal though it is often elevated in arteriosclerosis. History was negative with no report of previous illnesses. Mr. Abel was of an athletic build. The only peculiarity of his dietary habits was that he disliked all sweets and desserts.

The day before admission he had been unusually quiet and complained of his right leg being cold in spite of the warm, dry July weather. His yearly holiday had just begun and he had spent the day before mending the roof of his home. That evening after supper he just sat staring into space. Later, for no reason at all, he had a weeping spell. Mrs. Abel and their two grown sons thought he was overtired and he retired early.

During the first few days of hospitalization there were marked episodes of excitement and confusion

with memory impairment, disorientation, inability to think or concentrate.

Laboratory findings: (a) Urinalysis—Sugar plus 3. In health, no sugar is present in the urine; (b) Fasting blood sugar—228 mgm. In health the normal ranges 80-120 mgm.

Insulin therapy was begun with daily blood and urine tests. Mr. Abel received varying amounts of insulin to control the diabetic condition. Discoloration of the right leg and foot was noticed at this time and the limb was cold and numb. Coordination was poor. He was unable to grasp or hold anything with his right hand. He remained untalkative but during quiet periods he seemed to be in pain. It was noticed that the right foot was becoming cyanosed, accompanied by pain and swelling. A continuous ice-pack, reaching from the foot to above the knee, was ordered, which greatly relieved the pain. At the same time a partial paralysis of the right arm and hand was observed. This was believed to be due to a cerebrovascular accident, occurring simultaneously with the thrombosis in the right leg.

On July 9 a venous ligation was done on the right leg. Following this ligation, Mr. Abel became quieter and more cooperative. He was, however, still confused, speech was abrupt, coordination poor. With daily insulin his appetite improved. Encouraged to feed himself, he often gulped down his food, scooping it up with his left hand since he was still unable to hold a spoon or fork with his right hand. In the next few days his mental condition cleared considerably. On

Mrs. Macleod works at the Royal Jubilee Hospital, Victoria, B.C.

July 16, Mr. Abel was transferred to the general hospital, as surgery on the right leg seemed inevitable.

Laboratory findings: July 17 to July 30.

(a) Urinalysis—Negative for sugar.

(b) Blood-urea-nitrogen—July 17, 36 mgm.; July 19, 37 mgm.; July 21, 19 mgm. In health the normal ranges 10-20 mgm.

(c) Fasting blood sugar—170 mgm., gradually reducing to 137 mgm.

On July 17, following consultation, amputation of the right leg above the knee was decided upon. The ice-pack was kept on continuously even after the orthopedic preparation of the area. The operation was performed under cyclopropane anesthesia on July 18. The patient reacted normally, his chief request being "Chuck in more ice." Sensations of pain persisted for some time after the amputation.

TREATMENT

Morphine sulph. gr. 1/6 by hypo for pain p.r.n. Foley retention catheter for the first 8 days. Penicillin units 100,000 every 3 hours, intramuscularly. Daily blood and urine tests for sugar. Clinitest for sugar in urine was done on the ward before each meal. Protamine zinc insulin once daily, plus unmodified or crystalline insulin, the dose regulated to control the diabetic condition.

Diet: Liquids freely (diabetic); 2nd day post-operative, light diet; 4th day, full diet. *Diabetic formula:* P. 100 gm.—F. 40 gm.—C. 210 gm.

During the first post-operative week, the patient was restless, irritable, and resistive, sometimes fearful and emotional. Great tact was required of those caring for him. Especially at night he became hyper-emotional—singing hymns or weeping. At other times he had delusions of persecution, asking why he was being punished—begging his nurses to tell him what wrong he had done. Mr. Abel's night nurse (a registered male nurse) used to call him by his first name and discuss the current baseball scores, which seemed to afford the patient great satisfaction.

The patient's family were allowed to visit him daily although he did

not recognize them until the third day after the operation. As he often wept and begged them to take him home their visits were quite short. On the third day after the operation, July 21, Mr. Abel asked, "Is today July 4th? I know I was sick on July 3rd." This was one of the first hopeful signs that his mind and thoughts were clearing. Another good sign was a return of his sense of humor. He would make short, witty remarks which the family said were characteristic prior to his illness. With orientation re-established, improvement was rapid. Appetite improved, coordination was better. Mr. Abel slept well and sedatives were no longer necessary. Incontinence occurred less frequently. He was very sensitive regarding the loss of his leg and required constant reassurance. He was forgetful and almost daily wanted an explanation of his illness; the diabetic condition, why the amputation had been necessary, and how soon he could return home; how soon could he be fitted with an artificial limb and resume his former employment? He was encouraged to use his right hand and was proud of his improved accomplishment. The diabetic diet he found amusing, often encountering strange salad combinations which he had never eaten before.

The stump of the right leg healed without complications and during the last week before discharge Mr. Abel was allowed up in a wheel-chair for short periods each day. He was instructed about his diet, but the chief responsibility for checking and weighing his food was given to Mrs. Abel who spent hours sitting in his room studying the diabetic manual and consulting with the dietitian. The necessity for daily urinalysis and regular check-up with the family physician was also stressed.

PSYCHOTHERAPY AND REHABILITATION

The nature of his illness was explained to Mr. Abel. He was given constant reassurance to allay his fears. Praise for successful efforts in feeding himself and getting into the

wheel-chair helped to restore self-confidence. He was gradually prepared for the idea of an artificial limb and his desire to return to work was encouraged. His interests were rather narrow outside the home, being chiefly his work, the daily newspaper, and the local baseball team. An effort was made to interest him in handicraft and in more varied reading. The family eagerly accepted suggestions and greatly assisted in the patient's adjustment and rehabilitation. On the day before discharge Mr. Abel was seen by the same neuropsychiatrist who first treated him and who now pronounced him normal. This was on July 30, just 28 days after the onset of his illness and 12 days after the amputation.

Hidden Diabetes with Psychosis—3

Two months later, Mrs. Abel wrote that her husband was now entirely well. He was getting about on crutches, could use his right hand perfectly, had been measured for his artificial limb, and was very anxious to return to work. He was having insulin daily and following the diet faithfully. By the middle of October he was fitted with his leg and learned to walk with a cane. His only reference to his illness and hospitalization

was "It's lucky I was sick in July and August and did not have to miss the baseball world series broadcasts."

Final diagnosis: Diabetes mellitus; endarteritis obliterans, right leg; psychosis due to pathological intoxication; amputation, right leg.

CONCLUSION

This study seems to emphasize the importance of regular physical check-up. This is of even greater importance after the age of 40, when latent or hidden conditions may be found. Following a survey made in Oxford, Mass., October, 1947, the U.S. Public Health Service reported: "For every four known cases of diabetes, three more previously undetected and unsuspected were found through the survey."

Mr. Abel had called the family physician to see members of his family at various times but stated that, as he was always in excellent health, he had never had a physical check himself. A note from Mr. Abel's doctor two years after his illness states: "I saw Mr. Abel recently. His mental state was good and his diabetes was under good control. He is continuing to take insulin."

Epilation

At the present time there is no known drug that will cure hypertrichosis. The only method available for permanent removal of hair is, therefore, the destruction of the papilla and papillary vessels. Widely advertised depilatories only dissolve the hair shafts, never penetrating deeply enough to destroy the hair-producing papillae, and for this reason afford only temporary improvement. Nevertheless, women make extensive use of these preparations, not only because of the

simplicity of their use but because, to their knowledge, no other method is available. Depilatories may prove very irritating to the skin. The mechanical friction and irritation of depilatories and pumice stone serve to stimulate the hair papillae, so that the result obtained is not only coarser hair but hair which is more resistant to epilation by desiccation. Removal of hair by epilation forceps is likewise only a temporary measure, as the hair rapidly regenerates.

The best way to prevent accidents to the eyes is to wear glasses. A fact well known to eye physicians is that it is a rarity to have a man injured by broken glass from his spectacles. The missile that breaks the glasses usually expends most of its force on the lenses

or frames and the eyes receive little or none of it. It is also true that an object that hits the glasses gets such a sharp reflex act from the eyelids that, when it goes through the glass, it hits a closed eye instead of an open one and the sight is saved.

Institutional Nursing

The Value of Visual Aids

SISTER M. ROSARIE

Average reading time — 8 min. 6 sec.

IN THE REALM of education it is quite evident that, for the majority of people, the concrete picture is much more effective in the learning process than simple verbal instruction. Actually, this is just another way of stating the well-known axiom—"One picture is worth a thousand words." The concrete picture is one of the most effective means of preventing verbalism. According to Hoban, verbalism may be defined as the generic term applied to the use of words without appreciation of the meaningful content of the words or of the meaningful content of the context in which they are used.¹⁰ Teaching on an abstract level is usually the cause of this condition and consequently the student fails to grasp a complete understanding of the subject taught.

To overcome this difficulty concrete visual materials, known as visual aids, are receiving ever-increasing attention in the field of education. Naturally enough, history teaches us that illustrations came before the written word. Apparently the caveman felt the necessity of recording his ideas by drawings before he could read or write. This is perhaps our first introduction to visual aids. Visual education, if it is to be effective, should stimulate the imagination, arouse the interest, clarify ideas, as well as build up habits of independent study. Progressive educators in general are cognizant of these facts and are introducing well-organized visual programs as part of the school curriculum.

In keeping with these modern

trends in education, the nursing profession has gone forward by taking advantage of changing methods of teaching and by utilizing scientific knowledge. In the classrooms of the nursing school the use of visual aids fills a very definite need. Although the value of visual education is now well established, there are very few references to its use in nursing textbooks or in nursing journals. The purpose of this paper, therefore, is to enumerate some of the practical methods of visual education in the nursing school program and to emphasize the importance of correlating this material with the school curriculum.

TYPES OF VISUAL AIDS

Visual materials, which may be found valuable in the school of nursing, include field trips, models, specimens, objects, motion pictures, still pictures, and graphic material. These types are listed in their order of importance from the most concrete to the abstract. From this classification it can be readily seen that the *field trip* is the most concrete, as the student is brought into direct contact with the situation to be studied and is able to observe the various relationships as they actually exist. The field trip for the nurse can be the hospital ward, a visit to a clinic or to another hospital where first-hand experience can be gained.

Models, specimens, and objects are so universally used that they need not be discussed at length in this paper. A *model* is a replica of an object or a representation of the object in miniature. Perhaps one of the best examples of a model is the well-known Chase doll.

Sister M. Rosarie is classroom instructor at St. Joseph's Hospital, Saint John, N.B.

A *specimen* is a sample or part of an object. Among the specimens used in the nursing school classroom are the heart, brain, bone, and various other organs. The demonstration of the specimens is usually accompanied by a lecture and this is essential for the proper understanding of the lesson.

An *object* is something brought from its natural setting into the classroom. Various types of trays used on the hospital ward represent this type of visual instruction. Needless to say, the use of models, specimens, or objects supplies the type of experience that will make the lecture meaningful.

The use of *sound motion pictures* is probably the most popular kind of visual instruction in so far as the student nurse is concerned. It is true that this kind of visual education is not considered as valuable as actual observation, yet its importance as an excellent teaching device is well recognized. During World War II the use of motion pictures for teaching was quite general when accelerated programs had to be carried out for large groups¹³. In showing motion pictures there are psychological factors which enhance the desired result. Projecting films in a darkened room tends to focus the attention of the student on the screen by eliminating distractions. The rapid action and continuous changing of events are also effective in arousing and sustaining interest. A question frequently discussed is whether the motion pictures should be shown to the group at the beginning or at the end of the unit taught. If the purpose of the film is to arouse interest and raise questions, it should probably be shown early. If the purpose is to give an overall review of the unit it would seem more logical to have it at the end of the instruction.

Still pictures include *photographs*, *photographic slides*, and *filmstrips*. When these aids are accompanied by didactic instruction the student gains a mastery of the subject in a much shorter time. All three methods of teaching can be used on an all-

purpose or a tri-purpose projector. This type of projector is very convenient and is recommended for all nursing school programs. The simplicity with which an illustrated page can be shown in the course of a lecture to clarify an idea or to demonstrate a fact makes this instruction particularly useful. Photographic slides are also a great asset but they require more careful attention in handling and projecting.

Graphic material — that is, recording facts by means of graphs — is the most abstract form of visual aid requiring a fuller explanation for effective teaching. Graphic material, however, has a very definite place in the hospital field. The two most common forms of graphs used here are the line graph and the bar graph. The line graph is used on the patient's clinical record to show temperature, pulse, and respiration. The bar graph is also often used on this record to report the intake and output of fluids. It is one of the best means for the visual comparison of quantities. Different colors may be used in making these graphs to create increased visual attention to the chart.

These different types of visual aids do not cover the entire field but embrace the essential requirements for successful teaching in the nursing school. One could go on enumerating almost endlessly the many ways that instructors can make use of visual instruction. It must be remembered, however, that visual aids are merely supplementary devices and must be correlated with the school curriculum. In this connection read Heidgerken's⁸ excellent article on the necessity of the proper organization and administration of an audiovisual education program. In the past, unfortunately, this fact was often overlooked when visual aids were not correlated with other instructional material. For example, motion pictures would be shown to a group of students when the films were readily available but irrelevant to the teaching program at that particular time. With this type of instruction it is quite apparent that visual aids contribute

little, if any, to the objectives of the course.

SUMMARY

The importance of visual aids in the nursing school program has been emphasized. Visual aids being concrete in nature enrich the experience of the student and greatly facilitate verbal instruction. However, if this method of teaching is to offer a significant contribution to the learning process it must be organized and properly correlated with the nursing school curriculum.

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A Recruitment Idea

An ingenious group of nursing students at the Saskatoon City Hospital School of Nursing recently entertained prospective applicants at a novel tea and display. Under the caption of "Prelude to Nursing" an attempt was made to demonstrate, through



Star-Phoenix Photo, Saskatoon
Is it real?

posters and other exhibits, a fairly complete picture of the activities of a student, both on and off duty. Throughout the afternoon, school of nursing students conducted over a hundred enthusiastic guests through the classrooms, explaining the displays and answering myriads of questions. Particular interest in a display by the obstetrical department was evident. This included a modern incubator, information on baby feedings and infant care. The children's ward exhibit centred largely around play interests. Another popular display was the operating room scene with large dolls dressed as doctor, nurse, and patient, complete with incision. The emergency department depicted a well-splinted accident victim receiving prompt attention.

As the idea was to stimulate an interest in nursing generally and to make applicants aware of the advantages offered in various schools of nursing, a display of calendars, (continued on page 667)

Aux Infirmières Canadiennes-Françaises

Les Aides dans l'Équipe en Nursing

ANNE HAHN LINDBLAD et MILDRED STRUVE

Average reading time — 24 min. 38 sec.

(Suite de l'édition de juillet)

RÉSOLUTIONS ET PROJETS

Après 18 mois d'essai, l'opinion générale du personnel infirmier était que les services des aides, étant des plus appréciés, devaient être continués et organisés dans tous les départements. L'organisation de ce programme dans chaque département a demandé une énorme dépense de temps de la part des institutrices, à cause de la répétition du programme d'enseignement. Les meilleurs résultats furent obtenus en limitant les classes à des groupes de six ou huit, au maximum dix. Avec un plus grand nombre, le temps alloué à la surveillance de la pratique individuelle devait être fixé en dehors des classes d'enseignement. Les discussions et questionnaires étaient plus spontanées lorsque les groupes étaient actifs, facteur de première importance dans cette enseignement.

Les institutrices régulières des écoles d'infirmières n'étaient pas toujours disponibles à former un nouveau groupe d'aides, pour la raison que ces classes ne devaient pas interférer avec le programme d'études des étudiantes infirmières. Par conséquent, notre plan fut modifié comme suit:

La traduction de ce volumineux article, publié en premier lieu dans *American Journal of Nursing* (jan. 1949), a été faite bénévolement par l'Hôtel-Dieu de Montréal.

Mme Lindblad est administrateur assistant et chef de nursing ophtalmique à l'école d'infirmières, l'Hôpital Johns Hopkins. Mlle Struve, autrefois administrateur assistant et chef de nursing médical à Johns Hopkins, est maintenant à l'Hôpital Marine, Seattle, Wash.

1. Une institutrice à temps complet ou partiel, selon la nécessité, fut chargée de ce programme pour tout l'hôpital. Elle est responsable de la majeure partie de l'enseignement et de la surveillance individuelle. Elle doit être un agent de liaison entre les différents départements, répondant à leurs besoins, communiquant avec le département du personnel pour s'assurer des candidates qualifiées. De plus, elle explique le programme aux nouveaux groupes d'infirmières professionnelles et revise de temps à autres les activités des aides avec les infirmières en chef des divers départements.

2. Un programme de classes et de démonstrations d'une période de trois semaines, excluant le temps consacré à la surveillance individuelle, est donné à toutes les aides. Ceci nécessite l'accès aux salles d'étude afin que les groupes d'aides puissent commencer le programme d'entraînement en général à différentes époques. Les instructions et directives spéciales, qu'il faut ajouter à cause des différents besoins de chaque service, sont laissées à la discrétion de chaque département. Les classes commencent la première journée de l'emploi et se continuent environ un mois. Ce temps varie quelque peu selon le nombre du groupe et leur facilité d'assimilation. L'ordre des cours est tel, que l'aide peut se rendre utile dès le premier jour et devenir de plus en plus compétente à mesure qu'elle est formée et dirigée.

3. Une liste des activités, approuvées pour les aides, est affichée dans chaque salle de même que la cédule des classes et de la surveillance pratique lorsque les nouvelles aides ont reçu leur entraînement.

4. Il est désirable d'avoir dans le plan

d'ensemble des aides masculins; d'éliminer les infirmiers en assignant les ménages aux commissionnaires. Ces aides masculins devaient assumer les mêmes responsabilités dans le service des hommes que les aides féminins chez les femmes. Il nous fut impossible de former des hommes aussi compétents que les femmes, raisons pour lesquelles nos efforts ont été concentrés sur des aides féminins. Nous croyons qu'il est beaucoup plus difficile d'entraîner des aides masculins.

L'horaire suivant des classes et de la surveillance pratique est plutôt bref, mais il donnera une idée générale de son contenu. L'enseignement se fait durant cinq jours par semaine seulement. Les 6ième et 7ième jours sont employés à la pratique surveillée et au temps libre. (*Voir programme ci-inclus*)

LES AIDES EN SERVICE SPÉCIALISÉ

Nous avons réalisé qu'il était possible d'augmenter les activités des aides en les employant dans un service spécialisé.

Dans le service d'ophtalmologie, en plus des devoirs énumérés dans cet article, on enseigne aux aides à prendre les pulsations et la respiration du patient, d'apporter leur concours dans les divers soins thérapeutiques, et de prendre soin des enfants. Nous avons fait notre première expérience dans cette spécialité.

Une salle du département ophtalmique fut choisie dans laquelle on comptait deux infirmières pour trois aides. Ceci voulait dire qu'à un certain moment du jour il y avait proportionnellement une infirmière pour une aide en service, tandis qu'en d'autres temps, particulièrement sur la fin de l'après-midi et de la soirée, une infirmière pouvait diriger les activités de deux aides infirmières. A l'aide de ce groupe d'auxiliaires, il nous fut possible de donner une moyenne de 3.4 heures de service par patient, par jour, dans une salle d'une capacité de 24 patients dont le chiffre moyen d'hospitalisation par jour est de 20 patients.

En ne tenant aucun compte des dépenses occasionnées par les salaires

du personnel, de l'administration, etc., le coût de ce service (en utilisant le groupe d'aides infirmières) fut de \$1,350 par mois; par contre, en employant un personnel gradué, le coût pour le même nombre d'heures par jour, par patient, aurait été de \$1,800 par mois. On a fait ce calcul en se basant sur un tarif de \$180 par mois, salaire de base des infirmières graduées, et \$105 par mois, salaire de base des aides-infirmières. Nous sommes persuadées que le succès de l'organisation du programme des aides dans un département quelque soit le genre de service dépend beaucoup de la manière avec laquelle le programme est approuvé et accepté par tout le groupe des infirmières professionnelles, non seulement les infirmières du service général mais aussi les infirmières en chef et les surveillantes.

Après une étude sérieuse des résultats obtenus dans le département d'ophtalmologie, nous avons fait la même organisation dans deux autres salles du même service. Ce système fonctionne depuis deux ans et nous comptons que 61 pour cent des activités en ophtalmologie peuvent être accomplies consciencieusement et avec satisfaction pour les patients par les aides en coopération et sous la direction constante des infirmières graduées — un vrai modèle d'équipe.

CONCLUSIONS

Bien qu'il y ait eu de l'opposition de la part des infirmières graduées, nous pouvons affirmer tout de même qu'elles ont apporté une large coopération en préparant et rédigeant le programme; en l'organisant et l'adaptant dans les salles où les aides infirmières sont employées. Il fut reconnu que l'aide infirmière dépensait 100 pour cent de son temps au service immédiat du malade.

On ne doit pas confondre la quantité ou le nombre des soins à donner aux malades avec la qualité de ces soins. Cependant pour assurer de bons soins aux patients, il est essentiel de prévoir des heures additionnelles de service. En raison du manque de personnel chez les infirmières

graduées, ces heures ont été données par les aides infirmières. Le programme de répartition des soins a permis à l'infirmière professionnelle d'utiliser ses connaissances scientifiques et d'exercer son savoir-faire dans l'application des traitements d'un plus grand nombre de patients. Nous croyons que ce plan permettra également de maintenir une meilleure qualité de service tout en assurant le confort du patient.

En tout temps l'aide fait son travail avec l'infirmière professionnelle; la méthode du travail d'équipe est strictement observée. Selon le plan tracé, l'infirmière professionnelle donne ses instructions à son aide, note tous les détails spéciaux à considérer dans les soins des patients, lui recommande instamment l'importance d'accomplir seulement les tâches qui lui sont assignées et la nécessité de lui rendre compte de toutes les réactions extraordinaires des patients. A son tour, l'infirmière en chef encourage l'aide à demander tous les renseignements auprès de l'infirmière professionnelle qui en a la charge. Cette manière de procéder a contribué à renforcer le travail d'équipe qui, par la suite, a réalisé l'idéal du programme: meilleur service des malades.

Les patients des salles, chambres semi-privées et privées ont facilement accepté les services des aides; dans certains cas même, ils ont manifesté un enthousiasme marqué. Ce n'est que par exception qu'un patient s'opposera à recevoir les services des aides, car le public en général est intéressé et compréhensif aux problèmes du nursing et aux efforts que nous faisons pour donner de meilleurs soins.

Le conseil administratif de l'hôpital a fait preuve d'esprit de coopération en rédigeant de nouveaux règlements et en fixant des échelles de salaires proportionnés aux besoins de l'organisation et du développement de ce programme.

Les médecins, les chefs de service, de même que les administrateurs de l'hôpital, ont su reconnaître la qualité des soins donnés par ces employées

non-professionnelles et apprécier également la valeur des services de chacun des groupes.

A notre connaissance nous n'avons pas eu de départ parmi les aides-infirmières, ni aucune d'elles n'a cherché à obtenir un emploi soit comme infirmière professionnelle, soit comme infirmière pratique en dehors de l'hôpital.

Dans l'ensemble, la plupart des difficultés que l'on avait prévues au sujet de l'organisation et du maintien de ce programme ne se sont pas présentées. Il y a eu des critiques parce que nous recrutons des étudiantes parmi les finissantes des écoles supérieures qui auraient pu se diriger vers les écoles d'infirmières. Nous avons comme tactique d'encourager celles qui font preuve d'aptitudes spéciales et qui, d'après notre jugement, possèdent les qualifications requises pour être acceptées dans les écoles d'infirmières professionnelles ou pratiques. Nous en avons eu un groupe, particulièrement parmi les aides noires, qui se sont jointes aux écoles d'infirmières professionnelles.

Sauf l'augmentation des salaires, les chances d'avancement sont plutôt rares; cependant la majorité des aides semble trouver une certaine satisfaction dans les services qu'elles remplissent et n'ont aucun désir de se cultiver davantage, ni d'assumer plus de responsabilités. Par le fait que les conditions d'engagement et de travail sont bonnes, que le statut est officiel, la plupart des membres de cette catégorie a l'impression de rendre de réels services et en est vraiment satisfaite.

Quoique tous les aspects du programme n'ont pas été remplis aussi exactement que nous les avions tracés, ce qui est dû en grande partie au manque de sérieux chez le personnel infirmier en général, nous croyons que le service des aides entraînées et le développement de l'équipe du nursing a contribué à donner des soins meilleurs que nous n'aurions pu le faire sans les aides. Nous croyons également que les infirmières graduées et étudiantes, selon leur expérience dans l'organisation de ce service et

l'emploi de la méthode d'équipe, ont éprouvé une plus grande satisfaction à leur travail parce qu'elles pouvaient atteindre de plus près la perfection, dans les soins individuels aux patients. Voici la déclaration du Dr. Brown:

Personne ne peut prétendre que l'organisation d'un excellent service de nursing, variant selon les diverses exigences du milieu et établit selon les principes de base, soit chose facile ou encore puisse se développer d'une manière uniforme. Nul ne connaît la diversité des conditions d'un hôpital à l'autre et d'une agence à une autre, par conséquent nul ne peut approuver une méthode unique . . . surveillance copiée sans tenir compte de son adaptation. L'expérience, l'union et l'échange des idées, la critique des résultats obtenus, suivies d'une expérience encore plus vaste à base d'étude et d'analyse — voilà ce qui est à recommander. De plus, la profession d'infirmière, les organisations sanitaires comprenant les administrateurs de l'hôpital, et les laïques intéressés dans le changement social doivent être convaincus que les nouvelles méthodes du soin des malades doivent évoluer dans une juste proportion en nombre et en qualité.

C'est dans cet esprit d'union et d'échange de vues que nous avons fait connaître nos expériences, espérant qu'elles offriront des suggestions aux personnes intéressées à améliorer le service des malades en employant des aides-infirmières. Nous comprenons très bien l'importance d'étudier davantage cette question afin de fixer un critérium servant de base dans la détermination des relations entre les groupes professionnel et non professionnel et dans les investigations économiques relativement à l'hôpital et au patient. Nous conseillons fortement des études poussées dans tous ces domaines et la publication des résultats obtenus.

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* * *

Liste des activités approuvées pour les aides-infirmières de tous les départements:

Les aides-infirmières doivent remplir leurs fonctions avec ou sous la direction d'une infirmière professionnelle. Cette infirmière est entièrement responsable du soin des patients.

Les activités énumérées ci-après sont celles que les aides-infirmières peuvent accomplir. Tout autre travail qui relève des spécialités doit être écrit et affiché visiblement dans le département afin de renseigner le personnel infirmier du jour, de la soirée, ou de la nuit.

1. Technique du bain à la baignoire.
2. Technique du bain au lit.
3. Installation des malades pour la nuit.
4. Transport des patients en chaise roulante.
5. Transport des patients sur la civière.
6. Manière de donner et d'enlever les bassines.
7. Dosage des urines.
8. Distribution des pots à l'eau.
9. Dosage des excréta.
10. Température buccale et rectale.
11. Technique des sacs à eau chaude.
12. Technique des sacs à glace.
13. Application des coussins de caoutchouc.
14. Service des plateaux aux patients.
15. Aider les grands malades à s'alimenter.
16. Admission et départ des patients.
17. Préparation des patients pour examen physique.

18. Préparation des patients pour examen pelvien ou rectal.

19. Technique des lavements.

20. Introduction du tube rectal.

21. Technique des lits: fermés, ouverts, d'opérés, et d'urgence.

22. Assister les patients pour examens; recueillir, étiqueter, et enregistrer les prélèvements.

23. Soins aux patients des chambre d'isolement.

24. Conduire le patient à la salle d'opération dans un case d'urgence, lorsque l'infirmière professionnelle n'est pas disponible (avec permission de l'officière du département à chaque fois).

25. Surveillance du patient à son retour de la salle d'opération; après son réveil seulement et si son état général le permet.

26. Technique du lavage de tête.

27. Application des compresses chaudes ou froides (non stérilisées).

28. Ensevelir les morts.

29. Conduire les patients aux cliniques (ou dispensaires), au bureau de la caissière, etc.

30. Entretien des autoclaves.

31. Entretien des effets personnels du patient.

32. Entretien et préparation des cabarets aux traitements.

33. Entretien et stérilisation des objets.

34. Entretien des armoires aux médicaments (assigner cette tâche aux aides qui sont dignes de confiance).

35. Soins des instruments spéciaux tels que: le sphygmomanomètre, les appareils électriques, les aspirateurs à eau, etc.

36. Soins et arrangement des fleurs.

PROGRAMME DES AIDES INFIRMIERES

DATE ET HEURE	THÉORIE	SURVEILLANCE ET TRAVAIL PRATIQUE
<i>Première Semaine</i>		
<i>Huit heures de travail par jour sous la direction d'une infirmière graduée. Ce temps comprend aussi les heures de classes et de surveillance.</i>		
<i>1er Jour</i>		
Cours 1—2 hrs.	Orientation.	
Cours 2—2 hrs.	Entretien d'une chambre de malade.	
	<i>Démonstration d'un lit fermé.</i>	<i>Pratique.</i>
<i>2e Jour</i>		
Cours 3—2 hrs.	Transport d'un malade sur une chaise roulante ou sur une civière.	Répétition de la démonstration du lit.
		<i>Pratique:</i> transport du patient sur une chaise roulante et civière.
		<i>Pratique surveillée:</i> transport du patient sur une chaise roulante et civière.
<i>3e Jour</i>		
Cours 4—1 hre.	Dosage des liquides et des urines.	<i>Pratique:</i> mesures et fiches.
	<i>Démonstration sur la manière de donner une bassine et de faire le dosage des urines.</i>	<i>Surveillance:</i> pots à l'eau
	<i>Démonstration sur l'entretien des pots à l'eau.</i>	bassines fiches.
<i>4e Jour</i>		
Cours 5—1 hre.	Préparation des patients pour le repas.	<i>Surveiller</i> la préparation des patients et le service des repas dans les salles.

DATE ET HEURE	THÉORIE	SURVEILLANCE ET TRAVAIL PRATIQUE
<i>5e Jour</i>		
Cours 6—1 hre.	Préparation et installation pour la nuit.	<i>Pratique surveillée</i> de l'installation pour la nuit.
Deuxième Semaine		
<i>8e Jour</i>		
Cours 7—2 hrs.	<i>Démonstration</i> d'un bain au lit. <i>Démonstration</i> d'un lit avec un patient. Entretien journalier d'une chambre.	<i>Pratique</i> des bains sous surveillance.
Cours 8—1 hre.	Prévention des plaies de lit. Confort du patient. Usage des appareils.	
Cours 9—1 hre.	Revision.	
<i>9e Jour</i>		
Cours 10—2 hrs.	Température des solutions. Sacs à eau chaude. Sacs à glace.	<i>Pratique</i> de la lecture des thermomètres sous surveillance.
<i>10e Jour</i>		
Cours 11—2 hrs.	Lecture des thermomètres cliniques. Température des patients. Entretien du cabaret aux thermomètres.	<i>Pratique</i> de la lecture des thermomètres cliniques. Température sous surveillance.
<i>11e Jour</i>		
Cours 12—2 hrs.	Aide à l'admission et au départ des patients. Bain à la baignoire. Préparation des patients pour examen physique, rectal, pelvien.	<i>Pratique</i> de la préparation des patients pour examen physique, rectal, pelvien.
<i>12e Jour</i>		
Cours 13—2 hrs.	Divers examens ou tests. <i>Démonstration</i> d'un lit d'opéré et d'urgence. Préparation des cabarets à pansements. Surveillance des patients pendant inhalation d'oxygène.	<i>Pratique</i> sous surveillance.

Troisième Semaine

<i>15e Jour</i>		
Cours 14—1 hre.	<i>Technique des lavements</i> : évacuant, nutritif, huileux, salin. Introduction du tube rectal.	<i>Pratique</i> de la préparation des lavements. Injection rectale sous surveillance.
<i>16e Jour</i>		
Cours 15—1 hre.	Entretien et ménage.	
Cours 16—1 hre.	Entretien des autoclaves.	<i>Pratique</i> du nettoyage des autoclaves.
<i>17e Jour</i>		
Cours 17—2 hrs.	Principes d'isolation. Soin des patients isolés.	<i>Pratique</i> sous surveillance.

Total: 25-26 hrs.

Cette période de temps peut varier selon le nombre du groupe et leur facilité d'assimilation.

Trends in Nursing

Average reading time — 6 min. 24 sec.

One Nurse's Philosophy

A SHORT newspaper item by a nurse describing the Winnipeg flood makes one realize the essential fineness of people. After explaining that the nurses were on 24-hour call and had spent one night building a dike around the residence she goes on to say "never have I seen so much kindness, so much love, and so much concern shown by a people as at this time of crisis. I cannot help but think that somehow it will make us all realize the fineness of human nature. Even though the sorrow caused will hurt it will make us wise." This lovely thought expressed by a young nurse lets light into some of the dark corners.

Career Pamphlet

The new booklet "What You Want to Know about Nursing" published by the Department of National Health and Welfare has gone over very well. Requests for the book have been so great that the department is completely out of the first edition. We hope the second edition will not be too long coming from the printers.

American Recruitment Program

A new folder on practical and professional nursing entitled "Nursing Offers You a Choice on the Health Team" is now available.

Expanding Programs

Why does the United Nations concern itself with the problems of economic development?

Because the basic purpose of the United Nations is "to promote social progress and better standards of life." The Charter also calls for "conditions of stability and well being which are necessary for peaceful and friendly relations among nations."

All members of the United Nations have pledged themselves "to take joint and separate action in cooperation with the organization" for the achievement, *inter alia*, of "higher standards of living, full employment, and conditions of economic and social progress and development."

Arrangements have been made for international teams of experts to advise on economic development programs; the provision of fellowships for the training abroad of experts from under-developed countries; and the promotion of visits of experts to train technicians within under-developed areas and to assist in the organization of short-term training institutes. The secretary-general was also authorized to assist governments in obtaining technical personnel, equipment and supplies, and to arrange for other services including the organization of seminars on special problems of economic development and the exchange of current information on technical problems.

— *United Nations, Department of Public Information, Background Paper No. 60, Lake Success, N.Y.*

The Majority Needs to Know

"There is no single task before us," says Janet Geister, "greater than that of helping the majority of nurses to grasp these truths—the inexorable movements affecting medical and nursing science, etc.—and relate them to the new objectives in nursing education practice and legislation." The majority is defined as the main portion of the total nurses in the country whether or not they are members of our professional associations. "The strong profession is not the one of great numbers, but one whose members are well informed," says an authority. We tend to place more responsibility for decisions on the rank and file but this trend may result in harm unless it is

accompanied by a well thought out campaign of education and information. All nurses are concerned with the problems of good nursing care for patients but the right answer to the many problems cannot come unless the majority participate *in thought and action*. "Being well informed is to *understand the significance* of the issues and trends, and to know what can be and is being done about them." Understanding doesn't come in a flash. Back of it is the impact of a drop by drop rain of ideas and information, which finally comes to have meaning. "First we have the facts, then we reason from those facts, then we make a practical judgment."

Our present methods of helping the nursing profession keep abreast of the times is inadequate. The *Journal* is not enough; statistical reports are not enough. "Nurses should know about our *professional national associations*. The issues and trends before nursing are irrevocably tied up to our means of doing something about them." The purpose of organization is to act for nurses collectively. We need more reports that will interpret the whys and wherefores. "We need more interpretations. Every major issue needs to be broken down into smaller subjects and fully explained in order that the meaning of the whole can be understood. A series of simple, clear and brief releases, each treating an important part of the whole, can be ever so much more effective than a long piece giving us the whole story in one massive dose." We must recognize this need to inform the profession as a whole because the "degree of our progress is definitely related to the

degree of information that prevails among nurses."

—Candidly Speaking, R.N., May 1950.

The Team Approach

An article that strikes a new note appeared in *Public Health Nursing*, June 1950, under the title "The Team Approach in a Hospital Consultation Program." The program functions as follows: The maternal and newborn services of a hospital are surveyed jointly by a team composed of obstetric, pediatric and public health nursing consultants. Every phase of the hospital's activities relating to the care of maternal patients and newborn infants is evaluated. Following the survey, the team meets to discuss findings and to make a joint plan of suggestions and recommendations which represent the combined thinking of the members of the survey teams.

There are four major areas in which the public health nursing consultants may be of assistance to the hospital nursing personnel:

1. Evaluation of and strengthening the quality of nursing care given to hospital maternity patients and newborn infants.
2. Evaluation and simplification of nursing techniques as a means of making the most efficient use of available nursing service.
3. Strengthening the program of teaching mothers during the antepartal and postpartal periods.
4. Strengthening the liaison between the hospital and the community public health nursing agencies to promote continuity of care of patients between the hospital and the home.

Orientation et Tendances en Nursing

LA PHILOSOPHIE D'UNE INFIRMIÈRE

Une infirmière décrit dans un journal l'inondation de Winnipeg et ne peut s'empêcher

de s'exclamer, "Comme il y a de braves gens!"

Elle explique que les infirmières étaient en service 24 heures par jour, qu'elles ont passé

une nuit entière à maintenir un barrage autour de la résidence des infirmières. "Jamais," dit-elle, "je n'ai vu autant de charité, de bonté, et d'intérêt montrés par la population envers les uns les autres. Cette épreuve nous fera réalisé qu'au cœur de tout homme Dieu a déposé un peu de sa bonté. Si cette épreuve nous a causé bien des souffrances, elle nous a aussi donné confiance dans la nature humaine." Cette réflexion d'une jeune infirmière fait du bien et donne confiance.

NOS VIEILLARDS

Lors de leur assemblée du printemps, les infirmières de l'Alberta discutèrent l'un des problèmes qui demande, à l'heure actuelle, le plus de considération — celui des personnes âgées.

Grâce à une meilleure hygiène et à de meilleurs soins médicaux, la durée de la vie a été prolongée. Notre société compte un nombre de plus en plus grand de personnes âgées, qui demandent souvent des soins, soit à la maison, soit à l'hôpital.

Comment pouvons-nous leur aider? Comment prévenir les maladies du vieil âge? Comment mettre à leur disposition les ressources de la physiothérapie, de l'occupation thérapeutique? Combattre l'isolement par des récréations convenant à leur âge et à leur santé? La psychologie du vieillard malade? Toutes ces questions ont été étudiées. Ce problème est à l'ordre du jour.

CLARTÉ SUR LA PROFESSION D'INFIRMIÈRE

Ce livret, préparé par le Ministère National de la Santé et du Bien-Être, a été bien accueilli. Les demandes ont été nombreuses et la première édition anglaise est épuisée. Nous espérons qu'une deuxième sera prochainement mise à notre disposition.

LE RECRUTEMENT AUX ETATS-UNIS

Un nouveau dépliant sur la carrière de l'infirmière et de l'aide-malade, portant le titre "Nursing Offers You a Choice on the Health Team," est maintenant offert.

LES NATIONS UNIES ET LE DÉVELOPPEMENT ÉCONOMIQUE

Pourquoi les nations unies s'intéressent-elles tant au développement économique? Parce que le but de cette société est "de promouvoir les progrès sociaux et le niveau de vie." Elle considère aussi que "des condi-

tions de stabilité et de bien-être sont nécessaires si l'on veut que des rapports pacifiques et amicaux existent entre les peuples."

Dans les pays où le développement économique est en retard, l'on travaille à favoriser ce développement en y envoyant des équipes d'experts chargés de former des techniciens. L'on a offert des bourses d'études à l'étranger; l'on a organisé des journées d'étude, etc., afin d'aider ces pays.

LES INFIRMIÈRES DOIVENT ÊTRE AU COURANT

La deuxième grande guerre a amené des changements considérables dans les données de la médecine moderne. La même guerre a amené des changements non moins considérables dans l'économie de la société.

Tous ces facteurs ont une influence sur le nursing, qui ne peut plus marcher sur les traditions du passé. Il faut donc que les infirmières soient renseignées sur ce qui peut influencer les destinées de leur profession.

Une association puissante n'est pas toujours celle qui compte un grand nombre de membres, mais celle dont les membres sont le mieux renseignés. Il n'est pas facile de comprendre tous les changements qui peuvent se produire et comment ils nous affecteront — il faut s'arrêter et réfléchir profondément.

Il est mieux d'étudier une question à la fois que d'embrasser tous les problèmes. Renseignons les infirmières et que ces dernières soient avides d'information.

L'EQUIPE EN NURSING DANS L'HYGIÈNE PUBLIQUE

L'infirmière hygiéniste, à titre de consultante, a sa place dans l'équipe du personnel hospitalier. Son rôle est tout indiqué en obstétrique et en pédiatrie.

L'infirmière hygiéniste, a-t-on trouvé, à la suite d'une étude faite sur le sujet, peut rendre service à titre de consultante: (1) Evaluer et augmenter la qualité des soins donnés aux malades à l'hôpital, en maternité, et chez les nourrissons. (2) Evaluer et simplifier la technique, afin d'obtenir un meilleur rendement de la part du personnel infirmier. (3) Dans les consultations pré- et post-natales, un enseignement plus intensif peut être fait aux mères. (4) Des relations plus étroites peuvent être établies entre l'hôpital et les organisations d'hygiène publique, et entre l'hôpital, le malade et sa famille.

The spider, arch-enemy of the fly and a highly skilled weaver, has but one lens in each eye.

Lyle Creelman *Writes . . .*

Average reading time — 4 min.

ONE MOONLIGHT Saturday night in December, Dr. Dorothy Taylor, from the Ministry of Health in England, and I found ourselves winging our way over the high Alps in a large Swiss Air Constellation on a non-stop flight to Cairo. The sun rose just in time for us to catch a glimpse of ships on the blue Mediterranean below, the port of Alexandria to our right, the desert and the Nile, and then we were landing at the new King Farouk Airport about 15 miles outside Cairo. It seemed to be in the heart of the desert and, as we drove along to the city, we saw little but sand, with Arab tents and camels at intervals. I think my memory of the approach to Cairo will always be associated with the huge scarlet poinsettias which were seen in many gardens. Their brilliance was a startling, an unexpected contrast to the rather drab native costumes worn by the men, the black garb of the peasant women, the poorly clad children everywhere, the long-suffering donkeys, and the monotonous honking of automobile horns.

It was necessary for us to travel to Alexandria to our regional office headquarters that same afternoon. After a hurried breakfast at Shephard's, we selected a *dragoman* (guide), who had been one of the least insistent of those standing in front of the hotel

awaiting the uninitiated tourist, and set out to see something of Cairo. Our dragoman was Abdel-Fattah A. El Shaer. I wish I could describe his colorful costume. It also is a show for the tourist. No doubt when he has completed his day's work he puts on the simple native cotton tunic or, if he has been long enough in the game, he probably can afford British tweeds. With them he will wear the red fez, now almost a symbol of the extreme nationalist spirit.

It is interesting that nearly every dragoman professes to be an archeologist. He is willing to arrange any kind of tour to any part of Egypt. To Luxor—where he will take you to the Valley of the Kings and the ruins of the once beautiful temples. To Aswan—where the ancient Egyptians excavated by hand the famous granite and where in modern times a great dam has been constructed across the Nile. He will arrange a camping trip by camel caravan to the desert or a visit to an oasis.

Our time was limited. We had to content ourselves with a visit to the famous Mohamed Ali Mosque from which we saw the city of Cairo with its minarets and teeming streets below. In the distance were the great Pyramids and behind us the hills from which the tens of thousands of slaves dug the stone, carried it across the Nile and the desert, and erected those great monuments.

Our train to Alexandria took us through the very fertile area of the Lower Nile, where there live 2,000 people to every square mile and where the land produces three crops yearly. (In contrast Canada averages three people to the square mile.) The *fella*h (peasant) and his family, the camel, the donkey, the bullock, all moving along the palm-lined roads, the mud brick houses of the villages with the twigs and grass drying on the rooftops, were familiar sights by the time



Typical home of the Egyptian fellaheen.

we reached our destination, the port once such a familiar anchorage for the ships of the British Navy.

Since Friday, and not Sunday, is the religious holiday in Moslem countries we reported to the office immediately and were received by Sir Aly Shousha, Pasha, director of the Eastern Mediterranean Region. I should tell you that the purpose of our trip was to meet a request made some time previously by the Egyptian Government to WHO for an evaluation survey of their maternal and child health services. As nursing is an essential part of a health program for mothers and children it was decided that a nurse from WHO Headquarters might assist Dr. Taylor in this project. After an orientation in the headquarters we had a brief glimpse of the health program in Alexandria. It is interesting that this city is the only municipality in Egypt with its own health

administration. The whole of the remainder of the country, which is slightly larger than the province of Ontario, and has a population of 19,000,000, is administered from the government offices in Cairo.

In a country where language and customs are strange, where even the written letters and numbers convey nothing to one unfamiliar with the symbols, and where the gracious hospitality of the people makes it essential to take time for the drinking of innumerable cups of Egyptian coffee, in spite of every facility put at our disposal it was not easy for us to obtain an adequate background of information on which we were expected to be so bold as to make an "evaluation" of certain of the health services. I am sure you will want to hear something of nursing in this country where only a short time ago women wore the veil.

In Memoriam

Elma Ruth Coon, who graduated from the Ottawa Civic Hospital in 1931, died in Montreal on May 22, 1950, following a lengthy illness. She had served on the staff at the O.C.H. until 1940 when she enlisted with the group of Canadian nurses who helped staff military hospitals in South Africa. Returning to Canada in 1942, Miss Coon served on the Canadian Army hospital ship *Letitia* during the duration of World War II. Following the war she worked in Peterborough and Kingston and was on the Staff of Queen Mary Veterans' Hospital, Montreal, prior to her illness.

* * *

Jean Corbishley, a graduate of St. Michael's Hospital, Toronto, in 1910, died recently. Most of her professional life was spent in private nursing in Montreal and in the United States.

* * *

Jean Bernice (Myles) Jamieson, a graduate of the General and Marine Hospital, Collingwood, Ont., died on May 18, 1950, in Toronto. Mrs. Jamieson took her public

health nursing certificate at the University of Toronto School of Nursing and was on the staff of the Victorian Order of Nurses in Timmins prior to her marriage.

* * *

Catherine Vera Jones, a graduate of the Royal Victoria Hospital, Montreal, died in Ralston, N.J., on May 25, 1950.

* * *

Katherine W. (Ryan) Lang, who graduated from St. Michael's Hospital, Toronto, in 1910, died recently in Kitchener, Ont.

* * *

Betty (McRobbie) McConnell, who graduated from the Royal Victoria Hospital, Montreal, in 1936, died in Ottawa in May, 1950.

* * *

Jessie M. Mortimer, a 1902 graduate of Victoria Hospital, London, and formerly a supervisor of the medical wards there, died on May 14, 1950. Miss Mortimer had operated the Nurses' Registry in London for many years until ill health caused her to retire 10 years ago.

Student Nurses

Learning by Seeing

RUTH B. BROWN and SHIRLEY E. GIBSON

Average reading time — 3 min. 12 sec.

AFTER A BRIEF but pleasant trip by bus to Acton, we made our way to the office of the Baxter Laboratories of Canada Ltd. We were heartily greeted and briefed on our tour.

The first stop was the laboratory of the plant. A member of the technical staff explained in detail about the manufacture of parenteral fluids. All ingredients used in the making of intravenous solutions are tested prior to use. The already near-pure water is distilled by means of a compressor still.

In the mixing-room the solutions are filtered through charcoal from large glass-lined vats into stainless steel pipes leading into the filling-room. While in the vats a sample of each solution is taken and the proper percentage of its ingredients regulated.

Prior to filling with solution the containers are washed, given a soft-water rinse, and checked for flaws. The containers are fitted into pockets in a specially constructed washing-machine which contains a solution of washing soda and are washed six times with hard water and twice with demineralized water before re-checking for flaws.

The employees in the filling-room are dressed in plastic coats, caps, and rubber gloves and here the airways and corks are prepared by washing and inspecting. A machine fills the container with the required quantity of solution, a stopper and glass airway are inserted into the opening. These stoppers have previously been

treated with a special type of enamel to prevent chipping of the rubber. Each opening is covered with an inner rubber disc and an outer metal disc on which the name of the solution is marked. These are put on by a machine which, at the same time, creates a vacuum. All parts are secured in place by a close fitting outer ring.

The containers are then placed on skids and autoclaved at 232°F. under 15 pounds pressure for 30 minutes. When taken out of the autoclave a plastic indicator is checked to determine the sterility of the load. They are then left to cool for 24 hours.

The next day each container is held under a light in front of both a black and white ground to inspect for foreign particles. If any particles are found the solution is discarded. After inspection, the containers are given a hot-water rinse to ensure a clean appearance, labels are applied, and a metal band and handle adjusted. The finished product is placed in cartons and sent to the warehouse from where it may be shipped to any location in Canada.

Following our trip through the plant we visited the rabbit room where 60 rabbits were caged, starved, and ready for injection with specimens of solution. The test taken here is for pyrogen reaction. The rabbit's temperature is recorded prior to injection and at two-hour intervals thereafter. If the rabbit develops an elevation of temperature the whole batch of solution from which the specimen is taken is discarded.

One container from each autoclave load is also tested on aerobic and anaerobic mediae. These mediae are tested periodically to judge their

Misses Brown and Gibson are student nurses at the General Hospital, Galt, Ont.



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Apply: Any Indian Health Services hospital; regional Indian Health Services offices in Vancouver, Edmonton, Fort Qu'Appelle, and Winnipeg; or

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capability of producing bacterial growths.

After this most interesting and informative tour of the plant we were shown slides of instruments and equipment used in the past to administer intravenous solutions. In the light of modern methods such equipment appeared crude and amusing.

Following the tour of the plant we were entertained by several games of alley bowling, a tasty lunch, and concluded our trip by a sing-song on the bus on the way home.

Book Reviews

The Nursery Age—A Textbook for Nursery Nurses and Mothers of Young Children, by Helen M. Cousens. 280 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1949. Illustrated. Price \$2.50.

Reviewed by Mary Blackwood, Supervisor, Hamilton General Hospital, Ont.

This book presents an instructive outline on the care of young children, particularly the preschool age group. It reviews the care during infancy and points out the factors influencing growth and development. Chapters are devoted to the feeding of children, environment, physical activity, the care of the nursery, infectious diseases of childhood, and the public health services. The *Young Child in the Home* and *The Young Child in the Nursery* present different phases of the care of normal children. The book is well arranged—chapters are subdivided with clear-cut headings and illustrations and helpful summaries.

There are minor points which indicate the difference in the British point of view. There are indications of Britain's post-war difficulties—e.g.: "Government concentrated orange juice should be diluted with not less than eight times the quantity of water and sugar added to taste . . . Rose-hip syrup, tomato juice, black currant juice, or turnip juice may be given."

Graduate nurses could use this book as reference in teaching nurses regarding the normal child. It would be helpful in home



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nursing classes or for teen-age girl groups.

The book does not actually offer too much help for "The Nursery Age." Workers in our day nurseries would understand their charges better if they had a thorough knowledge of the background of children as presented by Miss Cousens. In view of the increasing popularity of nursery schools in this country and the shortage of trained personnel to staff such institutions this book might be used as a reference because the writer has had vast experience in a country where nursery schools have been established for many years.

Communicable Diseases and Their Nursing Care, by Evelyn Pearce, S.R.N. 392 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1949. Price \$3.25.

Reviewed by Dorothy McKeown, Instructor of Nurses in Pediatric Nursing and Communicable Diseases, Halifax Infirmary, N.S.

In her prefatory explanation Miss Pearce states that she decided to replace her original

book on "Fever and Fever Nursing" by this larger and more comprehensive one in order to meet the changes in hospital services and in the training of nurses that will no doubt take place with the passage of the Nurses Bill in England. This textbook reflects the experience of many years of teaching and study. Consequently, the volume is founded on a comprehensive knowledge of the old and new literature on communicable diseases.

Chapter I contains an introduction to microbiology and the author makes use of the new nomenclature for pathogenic organisms. Such topics as "hygiene of the mouth," "defences of the body," "methods of isolation," "air travel regulations," and "care of a communicable disease in a home" are typical of the varied matters of interest in communicable diseases that are given attention. The nurse's role as a teacher is stressed throughout.

Miss Pearce states: "The nurse forms a liaison between the general public and the medical and health authorities." The health of the staff of a hospital as an important

(ammonia dermatitis)

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factor in the control of communicable diseases is emphasized.

The outstanding feature of this volume is the author's ability to give importance to the more commonplace although necessary details of nursing care—an aspect of communicable diseases so often overlooked in similar textbooks on this subject. In a simple and straightforward style she makes the reader realize the importance of good hygiene of the mouth, diet, rest and sleep. Mention is made of the complications resulting from neglect of these factors.

The final chapter is devoted to questions used in state examinations and should be of value to the instructor. This is an excellent book for the use of both the student and graduate nurse.

Illustrated Handbook of Simple Nursing.

Compiled and illustrated by Wava McCullough, assisted by Marjorie Moffit, R.N. 238 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Price \$3.50.

Reviewed by Winifred Barratt, Registrar for Licensed Practical Nurses, Manitoba Department of Health and Public Welfare.

Wava McCullough assisted in making a job analysis of the work of the practical nurse for the Vocational Division, U.S. Office of Education. She states that "the need for illustrated work sheets at that time projected the idea for this book." Consequently there is a profusion of illustrations. The chief character is a whimsical nurse caring for the patient's environment, comfort, and hygiene; performing certain therapeutic, special, and aseptic procedures; also amusing and feeding the convalescent patient.

The cartoon-style illustrations are concise, clear, and attractive and the nurse portrays good body mechanics. The type used for the written content is hand-printing.

Unfortunately, some of the content is inconsistent. For instance, in care of rubber tubing — "If rubber tubing has not been used for several weeks, boil it for 15 minutes." Why? Again, in Care of Instruments — "Knives and scalpels must not be boiled more than 1 minute." Teachers and students in nursing assistant courses will enjoy studying the pictures in this book.

Orthopedic Nursing, by Robert V. Funsten, M.D., and Carmelita Calderwood, R.N. A.B. 660 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents:

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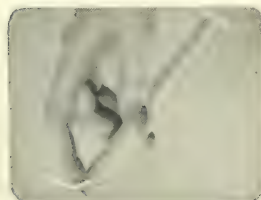
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- References:** 1. West. J. Obst. & Gynec., 51:150, 1943
2. Clin. Med. & Surg., 46:327, 1939
3. J. A. M. A., 128:490, 1945
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5. Am. J. Obst. & Gynec., 46:259, 1943
6. Med. Rec., 155:316, 1942
7. Med. Rec. & Ann., 35:851, 1941



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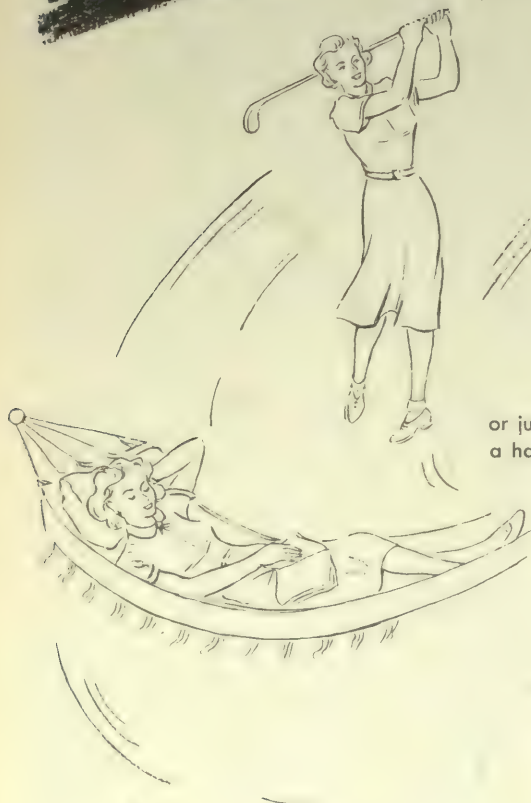
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1950



THE CANADIAN NURSE

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THE DUST
Charlotte Whitton

THE IMMEDIATE TASK
Ethel M. Cryderman

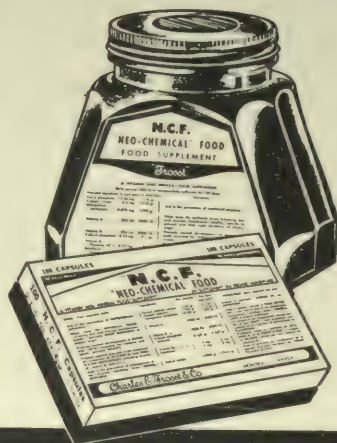


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YESTERDAY
See Page 684



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The Canadian Nurse

VOLUME 46

NUMBER 9

SEPTEMBER, 1950

NEW PRODUCTS.....	686
THE IMMEDIATE TASK.....	<i>E. M. Cryderman</i> 693
THE TRUMPET IN THE DUST.....	<i>C. Whitton</i> 699
THE INTERNATIONAL COUNCIL OF NURSES: A WORLD FORCE IN NURSING.....	<i>F. H. M. Emory</i> 713
CLOSING THE GAP IN THE TUBERCULOSIS PROGRAM.....	<i>M. Clark</i> 721
SERVICE SOCIAL DES GROUPE.....	<i>S. Paré</i> 725
THE NEW LOOK IN TYPHOID FEVER.....	<i>J. Thirlaway</i> 729
CHLOROMYCETIN THERAPY.....	<i>M. M. Davies</i> 731
IMPRESSIONS OF A NEW GRADUATE.....	<i>T. Potvin</i> 733
NURSES AND NUTRITION.....	<i>L. B. Pett</i> 734
NURSING PROFILES.....	736
LYLE CREELMAN WRITES.....	739
TRENDS IN NURSING.....	741
ORIENTATION ET TENDANCES EN NURSING.....	743
STRUCTURE STUDY COMMITTEE.....	<i>F. H. M. Emory</i> 745
INTERIM COMMITTEE ON PROVISION OF NURSING SERVICE.....	<i>N. D. Fidler</i> 746
EXCHANGE OF NURSES COMMITTEE.....	<i>N. S. Mackenzie</i> 747
A STUDENT AFFILIATES WITH THE V.O.N.....	<i>J. Graham</i> 749
BOOK REVIEWS.....	751
NEWS NOTES.....	756
OFFICIAL DIRECTORY.....	768

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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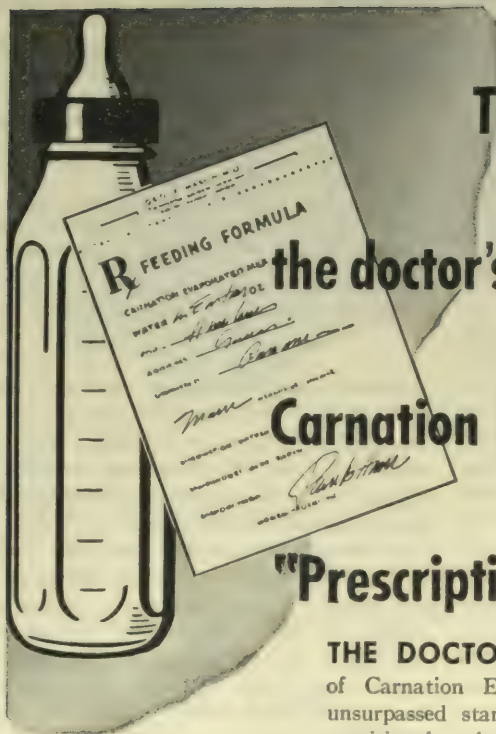
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Between Ourselves

Numerous queries have been received during the last few months regarding the desirability or need of nursing associations continuing the practice of sending **parcels of food to nurses in Great Britain**. We have no actual record of how many such parcels have been sent since the close of World War II but the probabilities are that the total would run into thousands of pounds. Should they be continued?

In response to these questions, Miss Gertrude M. Hall, general secretary, Canadian Nurses' Association, wrote to Miss Frances Goodall, general secretary of the Royal College of Nursing. Miss Goodall's reply was presented to the Executive Committee last June. They were delighted to learn officially that the situation over there has improved sufficiently that the enormous mass of food parcels will no longer be necessary. The Executive requested that Miss Goodall's letter be shared with the nurses of Canada that you all may know how exceedingly grateful our colleagues are for the assistance that has been given. Here is Miss Goodall's letter:

I was very glad to have your letter of 9th May as to food parcels which forestalled a letter I had in mind to write to you.

Although the quantity of food has not increased in this country, it is easier now to obtain a greater variation; therefore the rationing problem does not press quite so heavily and, except in the case of sick, elderly, or distressed nurses, the competent shopper should be able to secure an adequate and varied diet. This being the case *we do not feel that it is right for us to impose any further on the generosity of our colleagues in Canada*.

I shall never be able to convey to you adequately how much the gift parcels have meant to the British nurses and how greatly the contents have helped both psychologically and physically to keep the nurses going. The flow of gifts has been so continuous and well planned that our hearts, besides our "inner man," have been constantly refreshed.

The helping hand that Canada has held

out to us in time of difficulty in this way has, I am sure, done much to cement feelings of goodwill and friendship on both sides of the Atlantic. I do hope you will be kind enough to transmit to the generous donors in the strongest terms possible some idea of our gratitude and appreciation.

Apart from the actual gifts the administration of the scheme must have been a very formidable task but the administrators have carried out their work in an excellent manner and with much sympathetic understanding for which we are more than grateful.

* * *

Reference was made in our story about the convention to the discussion that developed during the luncheon for provincial registrars concerning the **international situation**. Though each one of us hopes and prays that the dangers that threaten may not plunge us into another devastating war, the nurses present were keenly aware that loving peace can never be a substitute for seeing the dangers of peace. They knew that wishful thinking is not only futile but perilous because it can blind us to the true facts and lead us to accept false premises for action. A small group was commissioned to sum up our thinking in the form of a resolution which later received the unanimous endorsement of the assembly. This is the resolution:

WHEREAS, Recent developments in international relationships suggest the possibility of a national emergency arising; and

WHEREAS, In such an event, nursing services will be of major importance; and

WHEREAS, The Canadian Nurses' Association, representing more than 30,000 registered nurses, would be able to assist in any needed mobilization of nursing services; therefore be it

Resolved, That in the event of a national emergency the president be authorized to call immediately a special meeting of the full Executive Committee of the Canadian Nurses' Association to plan and initiate appropriate action.

On Our Cover

This unusual picture was designed by **Joyce Rea, Vancouver**. It greeted us on our souvenir menus at the banquet during the recent convention. The totem poles typify the Indians who preceded the builders of the Lion's Gate Bridge and the Marine Building, the ships and planes of today.



on the one hand

an almost limitless variety of agents may cause pruritic dermatoses, presenting an imperative need for relief from itching.

on the other hand

the antipruritic employed should not contain potentially dangerous drugs, lest the lesion be exacerbated. Phenol (as in calamine with phenol), cocaine and cocaine derivatives are among the hazardous stimulating and keratolytic agents warned against in the literature:

1. Underwood, G. B., and Gaul, L. E.: J.A.M.A. 138:570, 1948. 2. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. 130:249, 1946. 3. Howell, J. B.: Arch. Dermat. and Syph. 53:256, 1946. 4. Gaul, L. E.: Hygela 23:280, 1945. 5. Gaul, L. E.: J.A.M.A. 127:439, 1945. 6. Lane, C. G.: J. Omaha Mid-West Clin. Soc. 6:45, 1945. 7. Miller, H. E.; Ayres, S., Jr., and Alderson, H. E.: California & West. Medicine 51:251, 1939. 8. Ormsby, O. S.: Diseases of the Skin, Philadelphia, Lea & Febiger, 1937. 9. Homans, J.: A Textbook of Surgery, Springfield, Charles C. Thomas, 1932.

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Edited by **PROFESSOR F. N. HUGHES**

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Description—Triple-formulation, tri-colored, coated tablets.

Dexobese A (morning)—d-amphetamine sulphate 5 mg., atropine sulphate (1/360 gr., aloin 1 $\frac{1}{8}$ gr.

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Manufacturer—G. W. Carnick Co. Ltd., Toronto.

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METHIOL GRANULES

Manufacturer—Debrulle Chemical Corp., New York. Canadian agents: Herdt & Charton Inc., Montreal.

Description—Each teaspoonful of granules represents 3 gr. of the amino acid, Methionine.

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Administration—As prescribed, dissolved in milk or formula.

WATERPROOF ELASTOPLAST

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Indications—Waterproof Elastoplast has been specially introduced for the treatment of injuries to patients whose hands are frequently immersed in water or who work in contact with grease, oil, and other liquids. The waterproof dressing should be replaced by one of the fabric Elastoplast when there is no further need for this special protection.

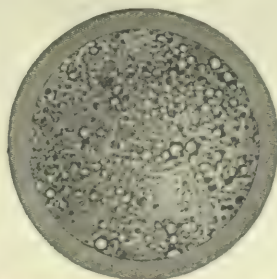
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Description—Adrenochrome Semi-Carbazone, a synthetic anti-hemorrhagic derived from epinephrine, without the vasodilator or hypertensive effects of the latter. It acts on injured capillary walls; it does not affect clotting time.

Indications—Capillary hemorrhages of various origins, both surgical and/or caused by disease or injury.

CALAMATUM

Manufacturer—Tailby-Nason Company of Canada, Ltd., Montreal.

Description—Contains calamine, zinc oxide, and campho-phenol in a flesh-colored, greaseless, adherent cream base.

Indications—For the relief of itching or burning skin conditions, such as from ivy, oak or sumach poisoning, insect bites, cold sores, and moist skin lesions.

Administration—Apply in a thin film over the area three or four times daily. Wash off once daily with warm water. No bandaging required.

ANABILE CHO

Manufacturer—Irwin, Neisler & Company, Decatur, Ill. Canadian agents: Herdt & Charton Inc., Montreal.

Description—Each tablet contains $1\frac{1}{2}$ gr. cholic acid and $1\frac{1}{2}$ gr. dehydrocholic acid.

Indications—Conditions due to biliary insufficiency. Chronic constipation due to lack of bile. Promotes absorption of fats.

ALENTERYL

Manufacturer—Junod Reg'd, Montreal.

Description—Each tablet contains iodochloroxyquinoline 0.25 gm., wood charcoal 0.15 gm.

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Administration—According to conditions. Usually one to two tablets 3 times daily after meals.

ESTROBENE TABLETS

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—Each scored tablet contains 25 mg. diethylstilbestrol.

Indications—Threatened abortion and, prophylactically, against habitual abortion, premature delivery, and complications of late pregnancy, particularly in patients with essential hypertension and diabetes. It is also said to be of value in endometriosis.

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Also contains significant amounts of the lesser known
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**The significance of these vitamins in human nutrition is not yet established.*

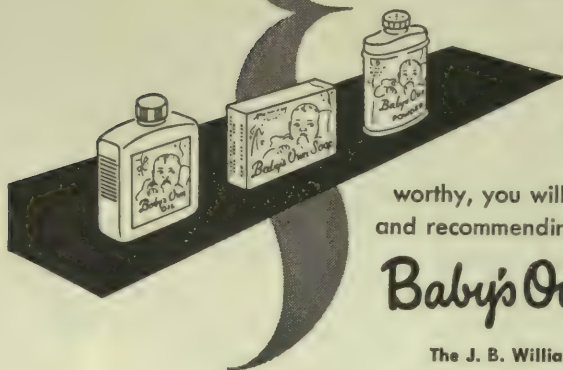
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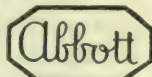
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The CANADIAN NURSE

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX

NUMBER NINE

MONTREAL, SEPTEMBER, 1950

The Immediate Task

ETHEL M. CRYDERMAN

Average reading time — 15 min. 12 sec.

THIS TWENTY-FIFTH anniversary meeting of the Canadian Nurses' Association can be a very great occasion for the organized nursing profession in Canada. Today, as never before in the history of nursing, wider horizons—ones which affect profoundly the whole future of nursing and, as a consequence, the health of the people of Canada—are challenging our profession. In a rapidly changing world, nursing like all else, is in transition and if progress is to be made major alterations with respect to nursing education and nursing service are inevitable. In addition, if adequate nursing care, which is now recognized as a social necessity, is to be made available a broader acceptance of responsibility for its provision by groups outside the nursing profession is essential. The Canadian Nurses' Association realizes that nurs-

ing is at the cross-roads and that today's stupendous challenges can only be faced successfully by the united and courageous efforts of its constituent members—the provincial associations.

This biennial meeting, which could appropriately be called the parliament of Canadian nurses, offers excellent opportunities for those from all parts of the Dominion to think and to act unitedly. This week important questions are to be discussed and it is



ETHEL CRYDERMAN

Miss Cryderman, whose presidential address was delivered on the first day of the convention, is district superintendent of the Toronto branch of the Victorian Order of Nurses.

hoped that decisions with far-reaching ramifications will be made. The character of the response of this group during the next few days to the problems and to the opportunities confronting the nursing profession may determine the course of action of the C.N.A. for years to come.

This address is to be confined to the presentation of the almost overwhelming problem of current and prospective shortages of nursing personnel and to review certain proposals, none of them new, which may assist in bridging the gap which now exists between the supply of nursing personnel and the demand for nursing service.

FACTORS INFLUENCING THE SHORTAGE

Canada's need for more nurses, like that of other countries throughout the world, has been steadily increasing since the beginning of World War II. The main contributing factors are: the economic prosperity of our country; an increased health consciousness on the part of the people; scientific discoveries in the medical field and their practical application; the tremendous expansion in prepaid medical care plans and in hospital accommodation; service to veterans; the new and increased responsibilities which the nursing profession has been called upon to meet; and the ever-increasing acceptance of the concept of the responsibility of government on various levels for the provision of health services.

Two years ago, shortly before the general meeting of the Canadian Nurses' Association, the new National Health Program was announced by the Prime Minister. The C.N.A. rejoiced in the establishment of this far-sighted plan for the health of the Canadian people, a plan which is the forerunner of the provision of adequate medical care for the entire population. Enthusiasm, however, was tempered with grave concern with respect to the shortages in nursing personnel. As nursing invades practically every phase in a medical care program, the C.N.A. immediately realized that the whole structure of

this plan to accelerate the extension of health services would be seriously jeopardized without a marked increase in nursing personnel in both the hospital and the public health field.

EXTENT OF THE PRESENT SHORTAGE

The estimated number of graduate nurses actively engaged in nursing in Canada in 1949 was approximately 31,000. As compared with the figures in the 1943 National Health Survey, this was an increase of 6,856. In 1948 there were 13,273 student nurses enrolled in schools of nursing. This was an all-time high and exceeded the 1943 figures by 1,914. An estimate of the number of auxiliary nursing personnel, that is, nurses' aides and nursing assistants or what are commonly known as practical nurses, in 1948 was in the neighborhood of 10,000. A comparison of this group with 1943 is not possible. As you will recall, in a submission to the Department of National Health and Welfare, prepared by the C.N.A. in 1946, the shortage at that time in professional nursing personnel was 8,700. Today, even with the substantial increase in both graduate and student nurses, the disproportion between the supply and demand in nursing personnel is practically unchanged. The nurse-patient ratio in many hospitals is dangerously low. At times hospital wards are forced to be closed and new bed accommodation remains unused. Official and private public health agencies are frequently unable to fill their authorized quotas. Constantly patients are unable to secure private duty nurses and expansion of health services, both in the hospital and in the community, is being seriously curtailed.

FUTURE SHORTAGE

Great difficulties are encountered in attempting to forecast the full extent of the future shortage in nursing personnel. Certain factors, however, are valuable guides. The probability of a large increase in student nurse enrolment is unlikely. In Canada approximately 10 per cent of

female high school graduates enter schools of nursing. This ratio is considerably higher than in either England or the United States. Unless changes are made in the present system of nursing education, there may even be a falling off in the present student nurse enrolment. It is recognized that facilities for the training of auxiliary nursing personnel are limited. It is known that the wastage in graduate nurse personnel is extremely high and that in 1948, through marriage, emigration to the United States, and other causes, the net increase in available graduate nurses was only from 600 to 800. As it was pointed out in a memorandum prepared last year by the Research Division of the Department of National Health and Welfare, at this rate of increase the present shortage would take ten years to overcome.

The following significant factors will add considerably to future shortages. Canada's population is increasing rapidly and as a young vigorous country, both through immigration and natural increase, continued growth is inevitable. Through medical research new treatments will be evolved which will require the services of professional nurses. As the implementation of the National Health Program progresses, the current acute shortage will worsen. Parallel with the expenditure of the Federal Health Grants to provincial governments for improvement in existing health services and for the development of new programs will be a demand for substantial increases in the number of public health nurses. The hospital grants, if fully utilized, will mean an additional 40,000 beds in Canada between the years 1948-52. It has been estimated that to service adequately the 15,030 beds authorized at the end of September, 1949, approximately 2,700 graduate nurses and 1,700 auxiliary nurses may be required.

The outlook is alarming indeed. Added to this alarm is a grave concern that large-scale plans to meet a situation that is threatening the whole fabric of medical care programs are

not underway. It is abundantly clear that, with the current and the potential nurse shortage, immediate and positive action is required to conserve nurse power, to increase the number of nursing personnel, and to ensure the permanence of essential nursing service to the people of Canada.

DIVISION OF NURSING

The National Health Program, whose successful implementation throughout the years is dependent so largely upon nursing personnel, has accentuated not only the need for the immediate assessment of the current nursing situation but the significance of long-term, large-scale planning of nursing services. The necessity for the nursing profession to share in this type of constructive planning on both national and provincial levels is apparent. As you will recall, the general meeting in Sackville was unanimous in its decision to request the Federal Government to establish a Division of Nursing with a highly qualified nurse as director within the framework of the Department of National Health and Welfare. The opportunities afforded the proposed division would include: acting in a liaison capacity between the Department of National Health and Welfare and the Canadian Nurses' Association and its constituent members—the provincial associations; obtaining from nursing organizations and other related sources information regarding nursing service and nursing education; assembling and making available statistical and relative information to appropriate groups. These activities would make possible an over-all appraisal of current situations, advanced planning for future services, and an invaluable consultative service. In both Great Britain and the United States divisions of nursing within governmental departments are functioning effectively. A delegation presented the request of the C.N.A. to the Honorable the Minister of Health and Welfare but, to date, a Division of Nursing has not been established.

A NATIONAL STUDY OF NURSING

On several occasions since 1946 the Canadian Nurses' Association, as well as the Joint Committee of the C.N.A., the Canadian Hospital Council, and the Canadian Medical Association, has recommended to the Department of National Health and Welfare that a broad-scale, nationwide study of nursing be conducted. It was also recommended that the committee to make this study should consist of representatives from the nursing, the medical, and the hospital administration fields as well as from education, social science, and the public. It was proposed that this study should include the following: an estimate of the nature and the extent of the need for all types of nursing service for a period of ten years; a job analysis of the duties now performed by professional nurses and those which may safely be undertaken by auxiliary nursing personnel; an appraisal of the present methods of preparing professional nurses; the desirability of operating schools of nursing on a different basis; a cost analysis relating to schools of nursing and the service of students; and an exploration of possible sources of financial support for nursing education. It is felt that such a study would provide a sound foundation for the constructive planning of present and future nursing service. The Federal Government has not been prepared to finance this study and to date assistance from other sources has not been secured. However, a national survey of nursing was approved late in 1948 at a meeting of the Department of National Health and Welfare by the directors of provincial survey committees, but a final decision regarding its implementation is to be held in abeyance until the present provincial health surveys are completed. The remedial and preventive aspects of a comprehensive survey of nursing at a national level, with the appropriate groups participating, has long been recognized by the Canadian Nurses' Association as well as by other allied groups.

CONSERVATION OF PROFESSIONAL NURSE POWER

The great shortage of present and potential nurse power has emphasized the need to focus attention on the conservation of the services of the professional nurse. Although a study of the function of the graduate nurse has not been made in Canada, certain methods to prevent the wastage of her special skills are generally recognized and could be successfully utilized. Graduate nurses perform services formerly assumed by the medical profession and laboratory technicians. They give nursing care which could be acceptably undertaken by auxiliary nursing personnel. Time is still spent on clerical, secretarial, and house-keeping duties. As a result, the opportunities for this group, whose services are so urgently required to render the maximum amount of skilled nursing care and to administer nursing services, are markedly decreased. This usurpation of time from legitimate duties is also causing considerable dissatisfaction and creating unrest among graduate nurses. The dissipation of nursing skills, which is affecting profoundly the amount of available professional nurse service, should be one of the major concerns of all those responsible for the provision of nursing care.

NURSING ASSISTANTS

The Canadian Nurses' Association has long recognized qualified nursing assistants as essential members of the nursing team and, wherever courses have been conducted under appropriate auspices, has co-operated actively on both national and provincial levels in their preparation. Indeed, in the majority of instances, organized nursing has taken the initiative in the establishment of schools and the development of curricula as well as in attempting to secure registration and licensing for this group. In hospitals qualified nursing assistants, performing simple nursing procedures under the supervision of registered nurses, are releasing professional nurses for duties which they alone are prepared to accept.

The number of trained nursing assistants in Canada is, however, very limited and, as this type of nursing personnel is one of the principle sources of the augmentation of nurse power, very serious consideration must be given to its extension.

*Today in Canada there are only 14 recognized schools for nursing assistants and in 1948 the total enrolment was under 400. Last year the estimated number of graduates from these schools was approximately 1,000. In only three provinces is there registration for this group. Two provinces have licensing acts. These low figures indicate the extent of the problem which faces those concerned with the provision of nursing services. The number of nursing assistants must be greatly increased and this involves many factors, among others, an increase in schools, an active recruitment program for students, and the more general acceptance of the important place of this type of nursing personnel on the nursing team. It is vitally important that nothing should be allowed to interfere with the extension of this source of nurse power.

THE INDEPENDENT SCHOOL OF NURSING

The present system of nursing education has been under review by distinguished and imaginative minds for over a quarter of a century. Considerable progress has been made in the preparation of nurses on the university level and, with further refinement and expansion, much more will be accomplished. The number of graduate nurses, however, from university schools of nursing, even in the years ahead, will be relatively small and with experience, as highly qualified persons, these nurses will be used mainly in specialized fields. The very large majority of clinical nurses—the group responsible for the greatest part of skilled nursing care both in the hospital and in the home—receive their preparation in hospital schools of nursing. Unfortunately, the ap-

prenticeship system still exists in these schools and very little differentiation is made between the use of the students' time for hospital nursing service and their preparation as professional nurses. Not only is the present system basically unsound from an educational standpoint but the resultant wastage of students' time is directly related to the present shortage of nurses.

The belief of the Canadian Nurses' Association—that nurses could be prepared for the clinical field in a shorter period than three years—was in part responsible for the present experiment in nursing education at the Metropolitan School of Nursing at Windsor. This demonstration of the preparation of a clinical nurse in a 25-month period in a school of nursing, which is financially and administratively independent of a hospital and thereby free to control its student time, is attracting the attention of the nursing world. The demonstration has reached its half-way mark. The first class of students has graduated and already there is reason to feel assured that, under proper conditions, an evolution in the preparation of the professional nurse for the clinical field is both practical and possible.

This demonstration, however, is but a beginning and the C.N.A. is now concerned not only with the securing of financial support for the continuance of the Metropolitan School of Nursing and the creation of other similar schools but with convincing the public, hospital boards, and governments that this type of nursing education is sound, both educationally and economically. As one of the fundamental purposes of the experiment was to demonstrate that satisfactory clinical nurses could be prepared in a shorter period than three years under an educational system comparable with that of other professions, the answer to the financial aspect of the problem is clear. The majority of other types of professional education receive state support, and what is more logical than to expect governmental assistance for independent schools of nursing? The

*Research Division, Department of National Health and Welfare, Oct. 1949.

significance of state subsidization for this purpose cannot be over emphasized.

Only proposals for attempting to meet the present and future nurse shortages, which have been approved by the C.N.A., have been presented. The need for immediate long-term, large-scale planning of nursing services is apparent. A national survey of nursing would give an over-all picture of the extent and the nature of the problem. A Division of Nursing, with a nurse director within the framework of the Department of National Health and Welfare, would provide effective liaison and consultative facilities between the department and organized nursing on both national and provincial levels. The conservation of professional nurse power would add greatly to the amount of skilled nursing service now available. The place of the qualified nursing assistant as a member of the nursing team is recognized and the need for a greatly increased number of this type of personnel is indicated. The establishment of independent schools of nursing for the

preparation of the clinical nurse would increase substantially the number of professional nurses. Lastly, it is recognized that government support for schools of nursing would heighten the quality as well as increase the quantity of graduate nurse services. There are many other factors which are related to nurse shortages. The above proposals, however, which strike at the very root of the problem, if acted upon, would have far-reaching results.

Today Canada needs several thousand more nurses. As the nation-wide plan for the expansion of health services continues to progress, the need, unless immediately and realistically tackled by all groups concerned, including the public, will grow immeasurably worse. Is the Canadian Nurses' Association willing to assume further responsibility in challenging others to share in the meeting of what may well become, in the not-too-distant future, a *national emergency*? Actually a decision to accept such a high responsibility is within the power of this biennial meeting.

National Immunization Week

(October 15-21, 1950)

There is so much stress put on the use of one antibiotic or another today that we sometimes forget that, though few of the communicable diseases will respond to any antibiotic, there are some diseases for which tried and tested immunizing agents are available. It is just as important to press active immunization programs against smallpox, diphtheria, and whooping cough as it ever was. National Immunization Week serves to focus attention on this need.

As advocates of good health practices, nurses everywhere should be alert for opportunities to urge the preventive protection that immunization affords. For example, have those of you who are in the maternity departments in our hospitals ever reminded

the young mothers of the importance of seeking advice from their physicians as to how early smallpox protection should be given their babies? Have you who are in pediatrics ever inquired of visiting parents whether the children have been safeguarded against diphtheria and whooping cough?

"But," you may say, "it really is none of my business and I have more to do now than I can do well. It is the public health nurse's job to preach immunization, not mine!" *How wrong you are!* It is the job of everyone of us—students, graduates, those in private practice, in hospitals—everybody. So make a mental note to do your share, particularly during this eighth annual observance—
October 15-21, 1950.

The Trumpet in the Dust

CHARLOTTE WHITTON, C.B.E., M.A., LL.D., D.C.L.

NOT ALL LIVES can be great but most lives can be well lived so that good is wrought by them in the ongoing lives of their people; thus, "No life can be pure in its purpose and strong in its strife and all life not be purer and stronger thereby."

What manner of woman was Mary Agnes Snively? What were the particular qualities and achievements which so set her apart among her contemporaries, and in fact through the better part of two generations, that not only those who called her friend but others, whom she had never looked upon, should have planned a Memorial to her of this particular form? For the Mary Agnes Snively

Memorial Foundation is ingeniously designed not only to keep her name fresh in the annals of Canadian nursing but also to assure, throughout the changing settings of the fleeting years, the continuous re-interpretation of the ideals and achievements which marked this woman as among those belonging not only to her own day but to all the tomorrows of her people and her profession.

She was a fine teacher in the science and art of nursing. Though great teachers are all too few and daily becoming fewer, we have had many of them in the schools and universities of this country to whom memorials throughout the land acclaim the affectionate gratitude in which their students have sought to make their names as enduring as the influence which they exercised in their lifetime.



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CHARLOTTE WHITTON

*And we all praise famous men,
Ancients of the College,
For they taught us commonsense,
Tried to teach us commonsense,
Truth and God's own commonsense
Which is more than knowledge.¹*

But there was something more in the character, life, and influence of Mary Agnes Snively than even these strengths, just as there was something almost indefinable about her great prototype, Florence Nightingale, between whose place and service in the evolution of nursing in the British Empire and the United States and the contribution of Miss Snively in Canadian nursing there are strangely arresting parallels. These women are of that company among all peoples in all lands of whom Browning wrote—

*Through such souls alone
God stooping shows sufficient of His Light
For us i' the dark to rise by.²*

MARY AGNES SNIVELY

Were Miss Snively still present in our daily life she would be 103 years of age. She was born in St. Catharines, Ontario, of Swiss paternity and Irish-Scotch descent in 1847. Ontario and Canada have benefitted greatly from a comparatively small Swiss immigration, most of which came from the Canton of Berne and many of whose members were marked by a peculiarly rich cultural background and unusual strength of character. Most of them were of Huguenot stock, whose forebears had suffered for their faith long before any fires of persecution had flamed in England. They were people who had dwelt in the heights of their mountain passes.

*There man's thought,
Rarer, intenser,
Self-gathered for an outburst as it ought,
Chafes in the censer!*₃

Some of the most venturesome minds in general and in health education in Canada came of these Bernese, notably the "Miss Martys," whom Queen's University, ranking them ablest of her women graduates, commemorates in the Marty Foundation. Others were the Huerner-Mullins of Hamilton, no less than three members of whom were pioneers in their chosen fields of medicine.

With the Swiss economy and practicality of mind, however, Miss Snively had the austerity, steadfastness, and sense of destiny of the Scottish. She was further blessed in the blend in her blood of Irish warmth, brilliance, light and charm, which are so often fated to burn out tragically in their own volatility unless, as in her happy case, they are mixed with the steadying solidity of some of those substantial breeds, held in such resentment by the Celt that it were discreet not to name them here.

A PIONEER IN TEACHING

Miss Snively's family had sufficient means and she herself sufficient perception and persistence to complete secondary education and enter the teaching profession. Such a course was much more of a derring-do in 1865 than today. When she went up for her normal training Confederation was still in the stage of conference. The discussions were engaging a group of only five provinces, their western limit of actual settlement about North Bay. There were small communities close to the old forts and trading centres—Sault Ste. Marie, Fort William, and Prince Arthur's Landing—and a few thousand inhabitants, mostly Indians and Metis, in the environs of our present Winnipeg. Westward were the grazing-grounds of the buffalo, ranging to the Rockies. Beyond the mountains, there were the small Crown colonies of the Mainland and of Vancouver Island, practically all of whose people had come by the sea route.

There were only a few, short railways. Travel was by stage route and water-ways. The small cities, towns, and settlements of Canada's three and a half million people at Confederation, the year in which Mary Agnes Snively came of age, were truly far apart, both in distance and in their necessary self-containment.

Education had been restricted, on the whole, to elementary schooling for the great mass of the population. Teaching had been ill-organized in its training and administration. Not until 1874 was secondary education put within reasonable reach of even the comparatively prosperous. Even then, authorities were emphatically opposed to the influx of girls which had followed its inclusion as part of the publicly financed system. The advantages of secondary schooling of a serious and academic nature might be said to have been a privilege restricted to boys. Most of the girls attended "finishing schools" which, only too often, proved just that, finishing off, as quite

unladylike, any aspirations for academic pursuits or any "career" ambitions which might have been stirring within the female breast and threatening to mature in feminism. It was just not "ladylike" for a woman to earn her own living. A life of penurious and genteel spinsterhood was preferable in "higher social circles."

Consequently, when Miss Snively persisted in completing a full, secondary education course and in entering teaching, she was one of a comparatively small number of women, blazing a pioneer trail in a profession much less established as a calling for her sex than the practice of nursing. It can be assumed, therefore, that she had within her an urge to the adventure, no less than the living of life, one of those of whom Clemence Dane writes, in the words with which Queen Elizabeth spurs on the young Shakespeare—

*and we climb
(You'll climb as I do) not because we will,
Because we must.*₄

INFLUENCES IN HER LIFE

Miss Snively was imaginative: all her work proclaims it. She would have been old and intelligent enough to share pleasurable, if without much comprehension, in the interest, excitement, and public acclaim when Florence Nightingale's name went round the world as the colorful Englishwoman and her nursing sisters came home from the Crimea. She would have been in early adolescence, with all its impulses to hero-worship, when Miss Nightingale focussed public attention on the needs of nursing by allocating the funds, raised as a nation's tribute to her, to the establishment at St. Thomas Hospital, London, of the first school for training nurses. From then onwards, for nearly 40 years, "The Lady with the Lamp" was to revolutionize hospital, nursing, and health services in England generally, by recurrently threatening to hurl (and on one or two occasions actually making good her threat) that highly explosive light of her so gloriously bright prestige into the dark and tyrannical recesses of vested authority and interest.

It may be that Miss Snively was influenced by the interest of her nursing friends in the United States of America—Louise Darch and Isabel Hampton, destined to be almost as influential in nursing in that country as she in Canada. There is probably valid ground for assuming that an intelligent, alert woman with a high sense of vocation, which everything about Miss Snively suggests she was, should be drawn to an identity of purpose and work with Florence Nightingale, who was the most considerable woman of her age, saving only the determined, able Queen with whom she shared the honor and affection of the Victorians.

In the year 1874, Dr. Theophilus Mack set up the first Training School for Nurses in Miss Snively's home-town of St. Catharines. It might be a fair surmise that this experiment caught the interest of the woman who, in 1882, applied to Bellevue Hospital, New York, for admission and training. Mary Agnes Snively took this step, not as a young and impressionable girl, but as a mature woman, 35 years of age, leaving a profession in which she was proficient and well established.

PURPOSE

One cannot but conclude that hers was a decision not only of deep conviction but of definite purpose. Here was a woman of vigor of mind, of experience and of culture. She looked out upon these strengthening developments in the Old Country, was familiar with their importation to the pulsing life of the new country to the South and, in contrast, she saw the needs of her own young and expanding land grievously underserved. She had taught and known young girls. She had, as all her subsequent life shows, a natural

aptitude for judging women. She doubtless realized not only the need of nursing for recruits from among women of quality and character, but also the need of such women for nursing as rewarding and satisfying work. For, as Canada developed and the pioneer stages of settlement were passed in the older East, there emerged a large body of well-educated young women, of serious intent who, without the sense of religious vocation or the impulse to withdraw from the world about them, were, nevertheless, comparably imbued with the instincts of duty, pity, and service which so mark those whose magnificent contribution to Canadian nursing has been made through the Religious Orders.

From the time that Miss Snively gave up teaching to her last days, lived out in the setting and succour of the hospital which bears the indelible stamp of her character, there is clearly discernible, to one who can know her only by the record of the written word and the loving testimony of those who still well remember her, a clear and definite purpose from which she never swerved. That purpose, for both Florence Nightingale and Mary Agnes Snively, embraced more than the recognition and excellence of nursing, though each woman will always be chiefly associated, in the memory of her own countrymen, with the evolution of modern nursing and hospital practice.

MISS NIGHTINGALE AND MISS SNIVELY

There are intriguing similarities in the scope and method of their activities, in their swift decisiveness and steadfastness but, more particularly, in the breadth and sweep of their vision and the directness of their aim and attack as they advanced from salient to salient in its realization. Both women turned to the service of nursing in their mature years. Each was a woman, versed and schooled in life generally, ripe in its broadest living and rich in its wider philosophies, before she selected a channel of specialized interest and practice. Nor did either of them ever relinquish the splendid vision of the broader, farther horizons as she journeyed, faithfully, the path of her own choice to those heights. The light, beckoning each of them onward, was, as Trevelyan wrote of Miss Nightingale, "a new conception of the potentialities and place in society of the trained and educated woman."

The immediate goal which Sir George Newman saw in Florence Nightingale's courageous, hopeful travelling was as certainly Miss Snively's—"the emancipation and education of the womanhood of the nation to be approximately equivalent to that of its manhood."

Nursing was a pursuit peculiarly in need of the particular attributes of women—a skilled service to human beings in sore need—the patients. In the conception of both women and in the particular practice of Miss Snively, nursing was also to serve as the medium for a very definite and especially qualified contribution of women to the happier living of life, not only for those in need of health care, but in the broader life of the nation as a whole. Florence Nightingale wrote:

Training has to make her (the nurse) not servile but loyal to medical orders and authorities. True loyalty to orders cannot be without the independent sense or energy of responsibility which alone secures real trustworthiness.

When, in 1908, Miss Snively had battered down the doors of the International Council of Nurses to lead her little new band of the Canadian National Association of Trained Nurses into the promised land of world recognition, the tenor of her message to the new organization was of conscious personal responsibility in the service of the nation itself:

Privilege means responsibility: a better century does not mean that it should minister unto us, but we to it. We can only be worthy of the great inheritance which

has been bequeathed to us as we use our larger opportunities to make our country and the world better and brighter and purer for each succeeding year.⁶

THE MINISTRY OF NURSING

A better century now, at this time of admitted crises in the survival of western civilization, can only follow if, to revert to Miss Snively's words, we seek to *minister unto it* and its needs. There you have the fundamental word in all the story of nursing, particularly Canadian nursing. Florence Nightingale made an evangel of nursing but nurses through the years form their own long and glowing line. They are too many and too many of them are too recent to risk any adequate recording here, but, from coast to coast in Canada, wherever men "desired loneliness," and their desire was bound "to bring close on their heels a thousand wheels, an Empire and a King," through the decades of the developing Dominion there were always those who served in the succouring of the sick—the nurses, religious or lay, inspired by their great ones who made of their profession a ministry—the ministry of nursing.

BREADTH OF SERVICE

A ministry, in simple lay phrase, is a mission of aid and service, above and beyond the mere doing of a job or the pursuit of a profession for gain. The leaders whom we remember in Canadian nursing have all left humanity and nursing better served and farther on their way for that they have lived. Nor was the ministry of any of them narrow nor channelled within the retaining walls of her own profession.

Florence Nightingale, in her concern over the men in Scutari, turned her mind and ministry to the homes from which they came, to the lack of care and sanitation, of proper food and housing, which left them weak of body though strong of will and heart in the hour of crisis and battle. It was over the whole field of public health and sanitation that she made her reconnaissance upon her return to England. The hospitals and health services of Europe and of North America, no less than those of Britain, engaged her exploring eye and exploding mind and pen.

The welfare needs of the people then centred largely in the Poor Law, its institutions and services, which had been the humane and revolutionizing last bequest to her people of the greatest Englishwoman of all time—Elizabeth Tudor. The Poor Law Commission, after the Napoleonic Wars, had, in the way of most Commissions, compiled a monumental report on which the bookworms of Parliament had fed for a generation. Florence Nightingale's contribution to public health, to hospitalization, and to nursing is so great that her incalculable services in the reorganization of the Poor Law infirmaries, the institution of the health and home visitor, and of the nucleus of the maternity and infancy services, under the local authorities in Great Britain, receive less than their due recognition; she could be as justly venerated as the founder of modern social work and public health in England as of nursing.

THE PUBLIC AS ALLY

Moreover, Miss Nightingale recognized the medical authority but was not inhibited by any shackles upon a junior and ancillary profession. She used every avenue open for the advocacy of the cause she urged. She wrote or spoke directly to anyone, from Prime Minister down, official or unofficial, directly or indirectly, if their place or power, their understanding and support were vital to the welfare of a cause that was of moment to the common weal. Florence Nightingale did not stop short of the Queen, whose high patronage and advocacy, in the end, assured the public acceptance of her work.

On a smaller stage in a younger country of fewer problems and population, Mary Agnes Snively played a comparable part. She had come, fresh from her

own graduation in 1884, to the Toronto General Hospital. There nursing service and standards were dolefully deficient in contrast to the revolution in hospital service and nursing training taking place in Europe and the United States. With no experience in nursing, other than her two-year course, but with the strengthening background of more than a decade of teaching and a firm grasp on the realities of life, she took up her task hedged in by opposition that was bred of ignorance and prejudice within her own institution, and by indifference, bred of ignorance and apathy in the community at large. "The great causes of humanity are never defeated," wrote Adam Smith, "by the assaults of the devil but by the slow crushing glacier-like mass of thousands of indifferent people."⁷

Like Florence Nightingale, Miss Snively attacked on both front and flank. She used both deployment and unexpected rear-guard sallies from friendly forces that she dropped in enemy territory. Such, for instance, were her devoted graduates whom she married off to medical men, to politicians, or to the business and commercial leaders, the latter of whose wives made them her allies on the Hospital Board or in other high places. (She and Florence Nightingale eschewed marriage and espoused celibacy, yet saw uses for matrimony, properly exploited and applied.)

Also, like Miss Nightingale, Miss Snively carried nursing problems and the needs and case of her nurses to the widest possible public by every medium open to her, particularly the missionary societies of the churches and the women's clubs, then just beginning. She was continuously on the public platform. Today she would probably have ingratiated herself into a different radio circuit each night. Results began to accrue in the growth of an excellent school of nursing, in the epochal departure of a separate nurses' residence, in recognition for Miss Snively across Canada, in the United States and overseas.

HOW DULL TO MAKE AN END!

Mary Agnes Snively had entered nursing training at 35 years of age. She had taken over "T.G.H." as she entered her 39th year. She was now past 60 and surely had earned surcease. But her vision and objectives had never been circumscribed nor personal. No school could survive in its own strength alone, unless all schools were comparably strong. No nursing alumnae could, of themselves, serve nursing well, functioning in faithful loyalty to their own school but unrelated to the advancement of the whole profession of nursing. The need of one school and its nurses was the need of all, so the pre-eminent position and high prestige, which she had acquired for her school and herself, she sought to share and, even as she shared, to strengthen it. So she founded the Canadian Society of Superintendents of Training Schools for Nurses in 1907 and acted as its first president.

Her contacts with nurses in Britain and the United States early revealed the community of problems, the comparability of the forces thwarting the fuller development of nursing in the entity of its own practice and profession throughout the countries of advanced nursing training. With Mrs. Bedford Fenwick of London, England, Miss Snively helped to found the International Council of Nurses, herself in the onerous honorary office of treasurer.

That was high recognition for a Canadian nurse in 1908! If there were but one thing that stands out in Miss Snively's life and work, it is the constant humility of her own sense of mortality. She would not always be here. She must plan and work and build to the end that "her work continueth, broad and deep continueth." She neither sought nor suffered the discounting of the work and place of the rank and file of Canadian nursing in distinction for herself. She might be the representative of Canadian nurses but she wished to remain always their servant. So, with a quarter century of hard work and achievement in the Toronto General Hospital behind her, and the haven of

her retirement in sight, she turned to what was to be the greatest of her legacies to her profession and her country—the creation of the Canadian National Association of Trained Nurses at Ottawa in October, 1908, and its full acceptance as an autonomous body in the world assembly of nursing, “the I.C.N.,” in that same twelvemonth.

THE ROAD WINDS UPHILL

Surely, in the call to minister unto this country and its people in this opening new half-century, there sounds a note, clear as a clarion, from the lives of these two women, whom the Canadian Nurses' Association holds in highest remembrance in this Dominion and in the Commonwealth of our broader loyalties.

*Does the road wind up-hill all the way?
Yes, to the very end.
Will the day's journey take the whole long day?
From morn to night, my friend.⁸*

THE C.N.A. — 1950

The Canadian Nurses' Association has completed more than two score years of unflagging leadership and unremitting service to the nursing profession and, what is much more, to the people of Canada. Its attainments have more than justified the faith of its founders and the loyalty of its members. It might well wear graciously its flowering laurels in a fine maturity of consolidation and repose. But that cannot be.

That cannot be among women who are called, not to the practice of a profession but to a ministry of nursing. Cleon's appraising challenge to Protus cannot go unmet:

*Thou in the daily building of thy tower . . .
Didst ne'er engage in work for mere work's sake;
Hadst ever in thy heart the luring hope
Of some eventual rest a-top of it.
Whence all the tumult of the building hushed,
Thou . . . mightst look out to the East.
The vulgar saw thy tower: thou sawest the sun.⁹*

TRUMPET IN THE DUST

We are in a day and country in which the extent and complexity of the problem of assuring the health and healing of all the people will demand the vision and qualities of women of the Nightingale and Snively cast. Canada requires, too, the loyalty and devotion of all the cohorts of nursing if the understanding of that problem, and of the full implications of the things needful to its happy solution, are to be grasped and applied to the furtherance of human welfare and social progress in the times now upon us. As Florence Nightingale in her 40th year turned to what proved to be her greatest contributions; as Mary Agnes Snively, in her 61st year, devoted herself to what was to be her most enduring memorial, so, in the 44th year of its existence, the Canadian Nurses' Association, and every woman within it who has taken the Nightingale pledge, must, like Rabindranath Tagore, pick up The Trumpet lying there in the dust—

*I was on my way to the temple with my evening offerings,
Seeking for the heaven of rest after the day's dusty toil;
Hoping my hurts would be healed and stains in my garment washed white,
When I found thy trumpet lying in the dust.*

*Has it not been the time for me to light my lamp?
 Has my evening not come to bring me sleep?
 O, thou blood-red rose, where have my poppies faded?
 I was certain my wanderings were over and my debts all paid
 When suddenly I came upon thy trumpet lying in the dust.*

*From thee I had asked peace only to find shame.
 Now I stand before thee—help me to don my armour!
 Let hard blows of trouble strike fire into my life.
 Let my heart beat in pain—beating the drum of thy victory.
 My hands shall be utterly emptied to take up thy trumpet.¹⁰*

THE LONGING WANT

There you have much of life, its purpose, its sorrows, its hopes and its strengths. Life cannot be lived without conflict, strife and pain, but these beat on to victory if purpose be firm and there be faith in identity with an enduring Power, mighty where we are weak, eternal where our mortal days are but fleeting as the shadows which we cast in the realities of immortality.

The Church of my faith—the Anglican—is a very practical one. In its Hymnal one section is frankly headed "Pilgrimage and Conflict." The Eastern philosopher and the Christian Church agree. In very simple phrase, life is livable if men and women feel that it is worthwhile, that what they are and do matters—matters to themselves, matters some little bit in the present and, somehow, in some small way, in the continuing scheme of things.

*Wherefore the soul, misknown, calls out to Zeus
 To vindicate his purpose in its life.⁹*

This is what marks man off from brute creation and insensate things—the deep hunger within the human being to be fulfilled; the "poor mortal longingness." Walter de la Mare phrases it "the unknown want"; "the destiny of me" is Walt Whitman's defining. "Thou hast made us for Thy self and our hearts are restless till they find their rest in Thee" is St. Augustine's answer.

FAITH

Faith was the very foundation of the purpose, courage, perseverance, and sustaining strength of the founders and builders of modern nursing in Britain and Canada. That could not be gainsaid in the lives of the Religious, but Florence Nightingale, Sir George Newman writes, possessed—

A soul anchored in the inexhaustible and enduring verities of her religious faith and her spiritual experience—still the greatest power on earth to move the minds and hearts of men and women.¹¹

Miss Snively had not only a deeply religious sense to which all who knew her attest, but she lived in a constant awareness of a new and practical alliance with the strength of God, whose instrument she felt herself to be as part of the Divine purpose. Time and again, she trod new and uncertain ways, assured always in the promise "I will go before thee and make the rugged places plain." Miss Edna Moore, director of Public Health Nursing for Ontario, and in Miss Snively's last class of students, tells how, opening the morning prayers (which with Miss Snively held as essential a place in the curriculum as nursing practice) the superintendent, on one occasion, asked for special intercessions—

A pray of thankfulness to God that through His grace a patient, who, through a nurse's carelessness, might otherwise have died last night, still lives; a prayer for that patient, still in the agony of pain; and a prayer for our nurse, who is in anguish and distress.

Belief and faith! These, then, must lie at the very heart of any life which would devote itself to a ministry of useful service, no less than to the pursuit of a profitable profession or a successful career and a comfortable acquisition of the material things of life, which can, indeed, be as pleasant and comfortable as they are perishable and of the dust of frustration. We are an age of confused, tired people, wearied in two wars and the intervening devastation of a bleak depression. We have discovered much, but still so little, of the overwhelming and pervading Power of the Universe, but we are so humanly inept in our handling of such Might that, like children with things beyond their own comprehension, we are more like to encompass our destruction than our own great benefitting. All this is, in part, because of the decay of faith.

In Browning's "An Epistle," Karshish, an Arabian physician, writes to a friend, recounting the tale of a man, named Lazarus, who had been buried three days in a trance from which he had been raised by a Master, who taught a strange new faith:

*Think, Ahib: dost thou think?
So, the All-Great were the All-Loving, too—
So, through the thunder comes a human voice
Saying, "O heart I made, a heart beats herel
Face my hands fashioned, see it in myself,
Thou hast no power nor may'st conceive of mine,
But love I gave thee, with myself to love,
And thou must love me who have died for thee."
The madman saith He said so: it is strange.*

As we lift the Trumpet from the dust of disbelief, disillusion, and despair, the first clear full notes blown thereon must be those of Faith—faith in the pervading power of the Spirit of God, as in man, who, informed with that Spirit, is more than the blood of his race and the soil of his land, who is indeed the one creation in which things material and things spiritual meet and merge.

COURAGE

From that note of Faith, first blown sharp and clear, flows another—Courage: courage of mind and of spirit and sheer physical courage. All of these have marked these women who have given greatness to the ministry of nursing. Courage, in the sure approach of death, is perhaps the highest form of courage exacted from men and nursing, which attends on both birth and death, walks daily with it. One of the rich memories of Miss Snively is her dismissal of the young charge nurse, whom she would not keep in attendance on her last night—"Surely, you do not think that I am afraid to die alone?"

There is another strength of courage, too—moral strength. Courage cannot survive in the dust of shallow, finite rationalism. That argues, as do many in our day and country, for the appeasement of compromise which it calls "common sense" and, sometimes, tolerance, when it means toleration of the evil and the vicious. Oh! The causes and the principles bartered in the name of common sense and tolerance when the counter is really ambition, greed, and expediency.

Christ was not tolerant of the money-changers in the Temple. He was violently abusive. He did not heed the rationalism of Peter and the other disciples urging Him not to go down to Jerusalem where He would offend those whom He was opposing and be most surely crucified. He went on to a death that it was in His Power to avoid. They became, it is true, the artificers of the Christian Church but He remained the Son of God.

PERSEVERANCE

When the note of Courage blows strongly, another note is in its very echoes.

There is one of the old hymns which pleads: "And crown Thy gifts with strength to *persevere*."

Perseverance is a virtue demanded of the nurse perhaps more than of most ministers. It is demanded in both its spiritual and practical strength; for you must

*... force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the Will which says to them: "Hold on!"*¹²

There are few notes more falteringly blown on the Trumpet today than this one of Perseverance, which, of course, cannot be sustained without some transcending faith in the ultimate justification of our life and effort here, even if that lie beyond the sight and knowledge of mortal men.

*The high that proved too high, the heroic for earth too hard,
The passion that left the ground to lose itself in the sky,
Are music sent up to God by the lover and the bard,
Enough that He heard it once: we shall hear it by and by.*¹³

The dust of futility mutes the Trumpet in the face of realities too devastating and defeating to be endured:

*Fooll! All that is, at all,
Lasts ever, past recall;
Earth changes, but thy soul and God stand sure.*

*Not on the vulgar mass
Called "work" must sentence pass,
Things done, that took the eye and had the price;
Over which, from level stand,
The low world laid its hand,
Found straightway to its mind,
Could value in a trice.*

*All the world's coarse thumb
And finger failed to plumb,
So passed in making up the main account;
All instincts immature,
All purposes unsure,
That weighed not as his worth yet swelled the man's amount.*

*All I could never be,
All men ignored in me,
This I was worth to God, whose wheel the pitcher shaped.*¹⁴

DISCIPLINE

But Perseverance can be a plaintive shrill note unless it be tempered by Discipline: not the discipline which is imposed from without so much as that which is the natural growth of mastery over one's own passions and impulses. We discipline ourselves and life disciplines us. We can better endure "the slings and arrows of outrageous fortune" if we have of our own strength built up the equanimity and peace of mind which accrue in mastery over the satisfaction of our own desires and wills, and in appreciation of the enduring values of life.

Moreover, it is in the blend of Courage with Discipline that another strength is found—the strength to follow the solitary way which the path of

duty often proves to be (again, it is Queen Elizabeth speaking to Shakespeare):

*For the high way
Is flowerless, and thin the mountain air
And rends the lungs that breathe it; and the light
Spreading from hill to everlasting hill,
Is not much nearer, nor half as warm
As the kissing sun of the valleys.*

But

*the man who hung twixt earth and heaven
Six mortal hours and knew the end (as strength
And custom was) three days, away, yet ruled
His soul and body so, that when the sponge
Blessed his cracked lips with promise of relief
And quick oblivion, he would not drink;
He turned his head away and would not drink;
Spat out the anodyne and would not drink.
This was a god for kings and queens of pride,
And him I follow.⁴*

It is often in the depth of suffering that the spirit of Prometheus is unbound, indeed, at last:

*To suffer woes which Hope thinks infinite;
To forgive wrongs darker than death or night;
To defy Power, which seems omnipotent;
To love and bear; to hope till hope creates
From its own wreck the thing it contemplates;
Neither to change, nor falter; nor repent;
This, like thy glory, Titan, is to be
Good, great and joyous, beautiful and free;
This is alone Life, Joy, Empire and Victory.¹⁵*

DEDICATION

And, in the suffering of all great Discipline, comes the deepening to the fine, mellow notes of Consecration in the ministry of service:

*Naked I wait Thy love's uplifted stroke!
My harness piece by piece Thou hast hewn from me.
And smitten me to my knee;
I am defenceless utterly.*

*Yea, faileth now even dream
The dreamer, and the lute the lutanist;
Ah! Must
Designer Infinite!
Ah! Must Thou char the wood 'ere Thou
canst limn with it?¹⁶*

PITY AND TENDERNESS

Moreover, in Discipline, too, the notes of Pity and Compassion and Kindness find play, even Tenderness, which must have place, though we know that the nurse is warned not to become "emotionally related" to her patient and in spite of Margot Fleming's delightful definition of Sentiment as "what

I am not acquainted with." And by that same token of pity and tenderness, be neither afraid nor ashamed of tears. In the release of tears, strength springs afresh from sorrow. John Milton tells us that even the gay and golden daffodils "fill their cups with tears" and Swinburne ranks tears as of our very being:

*Before the beginning of years
There came to the making of man
Time with a gift of tears . . . 17*

To the psalmist we are fed with "the bread of tears" and the shortest most poignant sentence in all the Bible is "Jesus wept."

Such storms spent, "we are serene and wise" and know the abiding comfort of Lizette Reese's

*Loose me from tears and make me see aright
How each hath back what once he stayed to weep,
Homer his sight, David his little lad. 18*

The power of Pity and Compassion indeed are of the very essence of life itself for they spring from this sense of the Oneness of all things.

*I find, under the boughs of love and hate,
In all poor foolish things that live a day,
Eternal beauty wandering on her way.*

*Ah, leave me still
A little space for the rose breath to fill!
Lest I no more hear common things that crave
The weak worm hiding down in its small cave.
The field mouse running by me in the grass,
And heavy mortal hopes that toil and pass;
But seek alone to hear the strange things said
By God to the bright hearts of those long dead. 19*

As each sees each as another creature of the same instincts and impulses as oneself, there comes that clarity of perception which shines through the last message of that nurse whose name will always live in our British story—Edith Cavell: "I realize that patriotism is not enough; I must have no hatred or bitterness to anyone."²⁰ Carried into everyday living, it is in this note that we find the power for an intensity of zeal in our own cause without, necessarily, a bitterness of antagonism to the advocacy of others. It is what should move us to give at least as fair recognition to strength as to weakness in our colleagues and to render not less than justice to our critics and even consideration to our enemies.

*'Twas a thief said the last kind word to Christ,
Christ took the kindness and forgave the theft. 2*

ARMORY

Of such are the notes on the Trumpet blown, ere each of us

. . . be gone

*Once more on my adventure brave and new;
Fearless and unperplexed
When I wage battle next
What weapons to select, what armour to endure. 14*

"Take to arm you for the fight the panoply of God" which St. Paul (*Eph. VI: 14 & 16*) defines as being "girt about with truth, and having on the breast-plate of righteousness . . . above all, taking the shield of faith."

Truth! *This above all: to thine own self be true,
And it must follow, as the night the day,
Thou canst not then be false to any man.*²¹

Knowledge of yourself, knowledge of the good, knowledge of the true, what more need you?

*Enough now if the Right
And Good and Infinite
Be named here, as thou callest thy hand thine own
With Knowledge absolute.*¹⁴

In St. Paul's magnificent letter to the Phillipians (*IV:8*) will be found all of that knowledge absolute:

Whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things.

Of all such have been the purpose, the qualities, the living of those whom we remember as good, no less than great, among the men and women who have served their people and guided their feet upon the paths to peace in all times and in all nations. They have all been people of Truth and Honor and, so, of character. Of such are the attributes, still needful, for the living of life hopefully and well not only in this country but in any place and in any age.

*There lies the port; the vessel puffs her sail;
There gloom the dark broad seas, My mariners.
Souls that have toil'd, and wrought, and thought with me . . .
 . . . something ere the end,
Some work of noble note, may yet be done,
Not unbecoming men that strove with Gods.
The lights begin to twinkle from the rocks;
The long day wanes; the slow moon climbs; the deep
Moans round with many voices. Come, my friends,
'Tis not too late to seek a newer world.
Push off, and sitting well in order smite
The sounding furrows; for my purpose holds
To sail beyond the sunset, and the baths
Of all the western stars, until I die.
It may be that the gulfs will wash us down;
It may be we shall touch the Happy Isles,
And see the great Achilles, whom we knew.*

*Tho' much is taken, much abides; and tho'
We are not now that strength which in old days
Moved earth and heaven; that which we are, we are:*

*One equal temper of heroic hearts,
Made weak by time and fate but strong in will
To strive, to seek, to find, and not to yield.*²²

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Reprints of this historical document may be procured at **25 cents** each from the *Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.* Schools of nursing will find this article excellent source material in the history of nursing.

Aluminium Clothing

The wheel of history seems to have done a complete turn. In the days when knighthood was in flower, warriors encased themselves in heavy metal armor and rode forth to meet any worthy opponent who cared to joust with them. Eventually the metal suits went into discard. Now it seems they are on the way back—in a most practical form.

Aluminium clothing in the form of the still-unnamed "X" cloth reached the U.S. market late this summer. Suits of X-cloth will not turn aside sword thrusts, like the old-time metal suits, but they will turn aside heat,

reflecting it back to the body for warmth in cold weather and reflecting away the hot sun for greater summer comfort. The radically new process uses a patented method of impregnating textiles such as nylon, cotton, rayon, and wool with aluminium flakes or powder.

An indication of the value of the process is given by the United States Testing Company which reports that a processed rayon lining, alone, will be 12 per cent warmer than the same cloth unprocessed, plus an 11-ounce wool lining.—*Aluminium News*

Punishment in 1700

Turning back 250 years ago to the English law of 1700 as it is described in "Non Compos Mentis or Laws on Natural Fools, Mad Folks and Lunatick Persons," the author, Lawyer John Brydall, reports that the criminal who murdered his father or his mother was first whipped then, after the blood was drawn, thrown into a sack with a hungry dog, a cock, a viper, and an ape and cast into the water. For the same crime, a man would re-

ceive no punishment if it could be proved that he was insane, since madmen were exempt from punishment for their acts. There was, however, one notable exception. Anyone, mad or sane, who killed or attempted to kill the King, would be punished in full, so sacred was the person of the King held.

—Department of Public Education
Institute of Living, Hartford, Conn.

The International Council of Nurses: A World Force in Nursing

FLORENCE H. M. EMORY

Average reading time—23 min. 12 sec.

"THE OLD ORDER changeth yielding place to new." This line from the pen of a well-known English poet is indicative of the half-century, the turn of which is marked by the year 1950. In all fields of life—political, economic, social, and health—changing conditions, precipitated by wars, by depression, and by scientific discovery and its implications, have been startling if not staggering. Look for a moment at our own Canadian scene. Here we have witnessed before our very eyes an evolutionary process in the political field which has changed us from a country predominantly agricultural to one which is to be reckoned with in industrial power: from one unit of an Empire to the status of full nationhood within a Commonwealth of Nations. Accompanying this growth there can be detected a change in economic status and social outlook. Developing gradually over the years we have seen the concept of social security which purposes to bring to the many rather than the few the necessities of a full life, through a more equitable distribution of the country's wealth. This has resulted in an improved standard of living for the population as a whole, including health and welfare services more commensurate with human needs. Plans for improved health, slowly evolving, supported by government funds already available, are providing, and are destined to provide ever more fully, improved living conditions for the citizens of this country.

On the international level similar forces are at work with machinery set

in motion which purposes to provide opportunities for an application of the principles of democracy in the conduct of world affairs and thus to knit together and to make more effective the efforts of the nations of which it is composed. I refer, of course, to the United Nations with its many units of specialized endeavor. Great in its potentialities for influencing public opinion and action this organization is bringing increased influence to bear upon the thinking and conduct of its member countries: it is shaping more than is realized current attitudes towards peace and peaceful living—towards health and healthful living. For in this international machinery and in its constituent unit where health endeavor is focused, the World Health Organization, is being forged an instrument



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which, as it develops through the years, will give leadership and inspiration in the field of health as will the United Nations in the broader political field. It is significant, therefore, that nursing has become identified with this world health movement and has been given an opportunity, through nursing personnel within the World Health Organization and through the establishment of a relationship between this body and the International Council of Nurses, to interpret professional opinion concerning the national and international significance of nursing, in this our day and for the second half of this century.

With a brief introduction which relates the organized profession of nursing to world machinery and to the evolutionary process with which that machinery is attempting to deal, we proceed to consider the present status of the International Council of Nurses as revealed in its objectives, its growth in achievement and prestige, some of its special interests, its relationships, its opportunities, and certain factors which limit its accomplishment.

PRESENT STATUS

It will be recalled that in Stockholm last year the conference celebrated the 50th anniversary of the founding of the I.C.N. which took place in the city of Buffalo in 1901. We are proud that there was Canadian representation at that meeting in the person of Miss M. A. Snively and that Canada became a member in 1909. With a revision of the Constitution and By-Laws of the Council in 1947, its objects in essence are stated thus:

1. To promote self-government by nurses in their associations for the purpose of raising the standards of professional education and practice.

2. To promote a full development of the nurse as a human being and citizen so that her professional skill may be brought to the many-sided service that society demands of her.

3. To provide a means of communication between nurses of various nationalities, creating opportunities for them to confer upon questions relating to nursing, affording facilities for the promotion of international understanding and making possible an interchange of international hospitality.

Hence it is clear that the aims of this world body are broadly based and that having been the first group of professional women to organize on an international basis the Council continues to accentuate those functions of coordination and interpretation which none but a body of this nature can perform.

The meeting in Sweden last year showed some 30 countries in full membership with the Council, representing approximately 350,000 members. In addition, the status of 7 countries formerly in full membership continues to be obscure and at least 16 others are in process of qualifying for full membership. To watch the avidity with which nurses from member countries, denied contact with the Council during the war years, met under the common banner of nursing—to witness the persistence and delight of certain countries granted re-instatement—to realize the influence of the Council upon the progress of nursing in countries seeking to qualify together with the prestige gained when they do—is ample proof that the quality and quantity of nursing service and preparation within these countries varies markedly in both concept and practice and that the Council is giving effective aid in the improvement of all phases of nursing.

In order to implement its objectives the Council holds interests which increase in both variety and importance. A good example of this is the work done (largely in the nature of study) by the many committees which function under the organization. For instance, the Membership Committee recommended to the conference in Sweden that the credentials of all affiliated associations should be reviewed to learn whether they con-

tinue to meet the basic requirements for membership—namely, that the national organization should be representative of all nurses of a given country, that its affairs should be controlled by nurses, and that the membership should be composed of registered (professional) nurses. A study, therefore, is being conducted through the medium of a questionnaire sent to affiliated organizations to determine the current position regarding these matters and also to learn the relation of other groups to the national association, including student nurses, midwives, who are not registered nurses, and all types of auxiliary personnel. When replies are received and tabulated the committee will be in a position to make recommendations to the Board of Directors convening in Belgium next year concerning these matters.

The countries which are seeking to qualify have been given an outline of criteria used in determining their eligibility and a suggested constitution and by-laws for a national association: these guides along with the assistance which can be given from International headquarters are helping them to put their professional house in order. Many of these countries are in need of a field visit by a member of headquarters' staff but so far funds available have limited this service to an appreciable extent.

The Nursing Service Committee, continuing to investigate the world shortage of nurses, is undertaking a study of ratios of nurses to patients both actual and desirable and also an acceptable ratio of professional nurses to the various types of auxiliary workers. The Education Committee continued its work on a Guide for Schools of Nursing, seeking to establish basic programs in professional nursing and as a new project is undertaking an extensive study of visual aids. The Economic Welfare Committee is making a study of economic conditions for nurses in all parts of the world. The Exchange of Nurses Committee is dealing with problems in that field and the Committee on the Ethics of Nursing is working along

similar lines. The committee concerned with Relief for Nurses in certain member countries made an appeal recently for tangible help for Korea to which four member countries responded. To make the questionnaire method used by all of these committees as effective as possible, expert advice has been sought from the Statistical Branch of the International Labor Office and the Statistical Branch of the World Health Organization.

As might be expected, one of the major functions of the staff at headquarters is the collection and distribution of information on matters relating to nursing education. This is in line with the Report of the Study Committee of the I.C.N. adopted in 1947 which envisaged the Council as a "fact-finding, standard-making, co-ordinating body responsible for the collection and dissemination of information concerning nurses and nursing at the international level." Marked growth has taken place in this area of function as member countries and related groups become aware of assistance readily available.

A further activity is found in the publication of *The International Nursing Bulletin* which appears quarterly, edited by the executive secretary, Miss Daisy Bridges. Articles appear from time to time in English, French, and German. The *Bulletin* is an aid in the interpretation of current developments in international nursing and merits a much wider circulation. To this end, the purchase of this publication for the library shelves of nursing schools and public health agencies is recommended.

After many years of planning and negotiation the Florence Nightingale International Foundation came within the general framework of the I.C.N. (as a legal entity) at the conference in Stockholm. Subsequently, a Council for the Foundation was appointed which held its first meeting in London in March of this year. Already, an able director to guide its activities is sought. The Foundation's Council, which has assumed responsibility for the development of certain phases of

nursing education, has considered an initial program, including the establishment of an information bureau on post-basic nursing facilities throughout the world together with certain research activities. After a time there should emerge clearly defined relationships between the work of the Florence Nightingale International Foundation within the International Council of Nurses and the I.C.N. as a whole, since at the present time both are concerned with the field of nursing education. Admittedly a long, difficult step has been taken in bringing this body within the orbit of the Council and in the long run benefit should accrue from closely coordinated efforts for the education of nurses in all parts of the world.

Perhaps the most striking development in the affairs of the organized profession on the international level has taken place in the area of relationships. The I.C.N. is now a member of the International Hospital Federation, has applied for membership in the World Federation for Mental Health and, most significant of all, is in official relationship with the World Health Organization. Resulting from this latter relationship certain tangible results can be attributed to the influence of the Council—namely, the appointment of two nursing consultants to the Secretariat; the establishment of a nursing section; and the setting up of an Expert Committee on Nursing which held its first meeting in Geneva last February. The committee is composed of appointees from seven countries and includes the executive secretary of the I.C.N. as a co-opted member.

At its first meeting the committee adopted the report of the Education Committee of the I.C.N. (presented in Stockholm in June, 1949) as a basis for discussion. A copy of it will be circulated to all governments in membership with the World Health Organization. Moreover, it is anticipated that the recommendations of the report of the Expert Committee (having been presented to the assembly) will be accepted: one of these

suggests that the I.C.N. be asked to collaborate in certain research projects sponsored by WHO.

Thus a cursory glance reveals that "the fields are white unto harvest," that much assistance in improved service and preparation is sought and that this is equally true of opportunities within the framework of the organized profession and of its relationships with outside bodies. In each of these areas further steps in development and coordination are desirable. So much for the need which is apparent and pressing. What is the chief deterrent in meeting it? It is a stark fact that the world is a large place and that much of the assistance which the Council is prepared and anxious to give is costly. To meet the opportunities at our doors, the staff should be augmented so that field visits could be made to evaluate the status of nursing and to stimulate progress in countries seeking help in the hope that ultimately they might come into membership with the Council. Added to the 16 countries having national associate representation are many others in need of the kind of help which can be given only through the field visit of a mature, experienced person. To increase the staff so that necessary time may be spent in travel and to meet expenses involved in the process, financial resources are required quite beyond the present ability of the Council to provide. Recent action regarding an increased per capita fee gives welcome relief but is still not commensurate with current opportunities. Herein lies a major problem which will have to be shouldered chiefly by member countries with financial resources.

NATIONAL OPPORTUNITIES AND RESPONSIBILITIES

With this fragmentary picture of the growing strength, actual and potential, of organized nursing at the international level let us examine its relationship to the association now in convention assembled. Clearly the effectiveness of all international effort is conditioned by the national units of which it is composed. It can be no

stronger in spirit, in performance, and in resources than the sum total of these. In the very nature of things the Council is limited by the professional and financial strength of its national constituents and the degree to which they put their shoulder to the wheel for the common good. The countries call; the barriers are down; but whether these opportunities are embraced or denied depends on the degree to which our individual and corporate imagination can grasp their significance and act upon it. In reality international achievement can be no more, no less, than the strength of that line of responsibility linking the district unit, the provincial association, and the national body with world necessities. The professional need of the hour will be met in the proportion to which each individual with sympathetic understanding and adventurous courage resolves to meet the challenge. If in times past there has been a place for the pessimist, for the defeatist (and this is doubtful) that time is not our time. As a professional group let us think broadly and deeply so that courses of action decided upon will influence the furtherance of world nursing.

GROWTH IN CERTAIN CONCEPTS

Passing on from a consideration of matters national and international and accepting the premise that corporate strength is dependent upon individual growth, we turn to consider certain qualities necessary to progress in this day so fraught with complexity and so replete with challenge. I submit that a growth in the concepts of maturity, of unity, and of peace are acknowledged essentials in present-day living. If this be accepted let us consider first what are some of the qualities of maturity which should be evidenced in the individual and the profession. Among many which could be discussed I single out three—namely, a sense of fitness, a sense of perspective, and a sense of values. Overstreet in a publication entitled "The Mature Mind," the reading of which I commend to you, puts forward the thought of constant growth,

through learning, as the underlying principle by which maturity is achieved. This is his statement: "Human beings can and must learn new facts and insights as long as they are in the world which, changing rapidly, needs constant adjustments." If this be a fair hypothesis "he who runs may read" its individual and corporate application.

I have stated that as a first requisite maturity requires a sense of fitness. The individual who possesses this sense is one who acts becomingly in life's situations, both unexpected and anticipated. A background of knowledge is predicated which, as it increases, is continually becoming wisdom. Thus knowledge through understanding, through insight, through experience, ensures fitting behavior when forced to make decisions. Moreover, responsibility is assumed willingly as life increases in complexity. Through an imaginative ability to see the point of view of others, favorable relationships are established so that maturity is reflected in an increasing capacity to work with and through others. This sense of fitness, therefore, is shown in the exercise of good judgment in all of life's relationships.

A second quality which will repay cultivation is a sense of perspective. So often we meet people quite incapable of standing back to view the total situation. They see one segment but their interest becomes so engrossed in that segment that they never see the whole circle; they go off at a tangent we say, or their horizon is limited. They are incomplete in concept, ineffective in action because they have failed to see their specific interests in the light of the total situation. The behavior of the mature person is determined through an analysis of inherent factors, yes, but always in viewing them as parts of a whole.

Again the mature person possesses a sense of relative values. She will be interested in many activities but will satisfy herself as to the relative importance of each. She will recognize that the spiritual dimension in life is

just as much a part of the individual as the physical, the mental, or the social and that all four need development in well-balanced living. For this person, faith, integrity, courage, purpose will be keystones in the development of character which maturity will consider to be an ultimate goal of life. Moreover, the person holding a mature philosophy of life will find inspiration in the thought that professional work, through personal worth, skilled service, and good citizenship, contributes to improved living for herself and for others and thus to life's ultimate goals.

And now we come to grips with certain attributes of the mature profession. Given individuals who strive for and have achieved a large measure of maturity, what are the particular qualities which one may reasonably expect to find in a profession composed of such individuals? Perhaps the first requisite in professional achievement is sustained interest. How many there are who make a good start but who fall by the way! They are incapable of patient, continuous effort over a long period of time. Enthusiasm, a necessary quality in itself, ensures a good start, but these persons forget that history has been a long time in the making and that worthy pioneers have lived and died without seeing the results of their labors. While mature members hold the fort through dint of trust and persistence, their ranks should be renewed continually by an influx of new members. It was Disraeli who said that the political party of which he was chief must be replenished constantly by a stream of new life if it were to survive. This principle operates in all of life's activities. Somehow then the wisdom of the mature must blend with the vigor of youth so that accomplishment may be perpetuated and enhanced.

Further the mature profession accepts responsibility for the solution of its problems. They do not falter, thinking the task to be too great. With an open-minded, stout-hearted approach and through sound, adventurous leadership they will seek first to define the problem and then to

solve it. There should be an urge for exploration, for path-finding, for trying new things in a new way. To experience the joy of the creative in meeting community needs more fully is to achieve the peak of professional maturity. Assuming the role of a profession, let us be professional in truth in seeking to solve our own problems through study and investigation leading to creative action. This constitutes a challenge to educational institutions to provide facilities whereby researchers can be prepared and to the profession to persuade promising candidates to undertake the preparation.

Finally, the mature profession will sense a relationship to life's broader interests within our own borders and beyond. In community service there will be a reaching out to join forces with other constructive elements and thus to strengthen and increase the total service rendered. *To realize that in this age national and international effort is as much a part of life's opportunities as is community enterprise; to recognize that the national and international interests of nursing are bounded by the numerical and financial strength of the provincial and district association; to accept the fact that through strong support of professional effort at all times, influence can be brought to bear upon world effort; to believe that full professional participation is the key to professional achievement both at home and abroad is to be mature in outlook and practice.*

Given the mature individual influencing the achievement of maturity in life's interests and relationships, a second concept, that of unity in purpose and action, will be more readily achieved. It is impossible to watch current trends in the fields of medicine and nursing without detecting the increasing degree to which health forms the common denominator in the objectives and practice of both: no longer is there a marked cleavage in the aims of those whose work is predominantly curative and those whose specialty is prevention. The current emphasis is upon unity, not division; upon one goal—health

for the individual, the community, the nation, and the world. This is seen in the administrative practices of health departments and hospitals: both work together to give the best possible health care to the individual for in no other way can continuity be established. When prevention fails and hospitalization is indicated the individual remains the minimum time in the institution, receiving care which has health significance, and is returned at the earliest possible moment to the community where increasingly the public health nurse in some phase of her practice picks up the thread and carries on. Again this principle is operative in an evolving concept of nursing care. No longer is it thought that nursing relates to illness more than it does to health with the consequence that all branches of nursing, whether predominantly curative or preventive, contribute to one field and hold one goal in common—more health for the people. Carrying this thought a bit farther we see that such a philosophy affects the preparation of workers for both medicine and nursing. Prevention is introduced into medical and nursing curricula in order that the clinical practitioner in preparation may be given a start toward health knowledge and practice. In fact for some years in the undergraduate work of certain university nursing schools the teaching of nursing includes the preventive as well as the curative and the degree obtained qualifies the recipient for the practice of nursing in both of these fields. And, further, in certain schools of hygiene, the hospital administrator is prepared for his first degree, since it is held that he will assume responsibility for an institution which represents one unit of community health endeavor. Of special interest is a recent development in the teaching of schools of hygiene and of nursing in certain university centres whereby doctors and nurses, preparing to administer public health and public health nursing services respectively, have met in joint seminars to discuss their mutual problem.

This philosophy is further exempli-

fied by the Community Welfare Council which aims, by joint planning and action, to make possible at the community level health and welfare services, both efficient and economical. There is evident also in the planning of convention programs within the organized profession a desire for all to meet together in open or general sessions and for a cross-section of the personnel of all branches of nursing to gather in work groups to grapple with problems common to all. Yes, the profession is united today to a degree thought impossible a quarter of a century ago. More than any other trend it may help us to negotiate future hurdles with success.

There remains but one further concept, the growth of which can be touched upon only. I refer to the concept of peace. Certain subversive use of scientific discovery and recent ominous events in the political realm to the contrary, there is a real sense in which the ideal of world citizenship and its potentialities for peace have taken hold of the individual and the nation: the preservation of peace through mature attitudes and practices, through unified purposes and actions, is of truth our most vital concern. The greater the degree of maturity shown by understanding compromise and the greater the will to unite through a sacrifice of secondary interests for the sake of corporate good, the greater will be the likelihood of the effective maintenance of peace. Unlike certain other benefits bestowed without the asking, a state of freedom, of peace must be planned for, worked for and, if necessary, fought for by each succeeding generation. Thus it is emphasized that each year of peace is a year of victory. If the individual through conviction and through intelligent, persistent effort may become a vital force in the moulding of public opinion, how much greater can be the influence of thousands of professional workers in every corner of the globe banded together with similar professional needs and aspirations. Focusing upon professional problems and their possible solution, more understanding is gained

and the value of peaceful ideals and methods enhanced. In these momentous days with their conflicts in ideals and practices crowding in upon us, we are reminded of the quotation: "In such great developments twenty years are but as one day and there may come days which are the concentrated essence of twenty years."

Truly these days, with their unprecedented opportunities for professional enrichment and world solidarity, are ours. It behooves us to embrace them through supporting to our utmost the international organization which has influenced and will influence increasingly the best interests of nursing and of peace.

In the Good Old Days

(The Canadian Nurse, September 1910)

"Should a hospital be a municipal institution or be conducted by philanthropic societies or church organizations? There are many who condemn a municipal hospital for the main reason that it stifles philanthropy and, again, that politics, entering into the management of the institution, renders it inefficient . . . As hospitals were never instituted simply to develop philanthropy but to care properly for the sick, it seems to me that the system which, taking into account local conditions, will provide the best-equipped hospital is the one to be chosen . . . There is no good reason why men and women of wealth should not give to a municipal hospital . . . it is a great comfort to be assured a fixed income and be relieved of the annual task of raising funds by subscription."

* * *

"It is a good plan to combine the positions of superintendent of nurses and matron under one person. The duties interlace so much that less friction will arise if the superintendent of nurses, besides having charge of the training school, be responsible for the housekeeping."

* * *

At a meeting of the Executive of the Ontario Nurses' Association the question was raised as to "what position the Association

wished to take on Woman Suffrage . . . After some discussion the question was left over for further consideration."

* * *

"Montreal, Winnipeg, Vancouver, Hamilton, Brantford, and now Toronto have established the work of the School Nurse as an integral part of the work of the Public Schools."

* * *

"As we go to press the news is received of the death of Miss Florence Nightingale, O.M., in her ninetieth year. So closes the good and great life of one of the noblest of England's daughters."

* * *

"The nursing of the future is visiting nursing. All developments of the present day point that way. Tuberculosis nursing, school nursing, social service work in connection with the hospitals, factory nursing—all are along visiting nursing lines. . . One of the most recent extensions of visiting nursing is found in the nursing care given to the sick policy-holders of one of the large insurance companies—the Metropolitan Life Insurance Co. This branch of visiting nursing was started in New York in June, 1909. . . It is more recent in Canada. Montreal started it in January, 1910; Ottawa in March."

No one likes to hang about for hours waiting for work and then to be swamped by too much of it; nor does your stomach. It works best and without grumbles if it is fed at regular times and without rush. And so if you are tired or worried you should eat a

smallish meal and make up for it later when you are less rushed or upset. Some people digest quickly but can't take much at a time and for them frequent though small meals may be necessary. Conversation at meal-times should be cheerful and peaceful.

—National Health Association

Public Health Nursing

Closing the Gap in the Tuberculosis Program

MURIEL CLARK

Average reading time — 13 min. 36 sec.

AROUND 1900 several state and town Anti-Tuberculosis Societies came into existence. By 1901 the Canadian Tuberculosis Association took its place as one of the most important health bodies. People had become tuberculosis conscious. They organized to protect themselves and the campaign was hopefully begun. The cause of tuberculosis had been found, the source of infection was fairly well understood, its mode of transmission fairly well grasped, sanatoria were being built for the care of all stages of the disease, and the then ultimate in treatment—fresh air, food, and rest, together with the continual education by doctors, nurses, and especially the cured patient himself—seemed to point to a swift and complete eradication of the disease.

Unfortunately, this hope has not been realized. Some 50 years of effort have taught us many things. Although the death rate was cut in half during the first 30 years of the campaign and reduced another 40 per cent in the next 10, we have learned that tuberculosis cannot be eliminated by applying a few well-planned rules to obvious situations. Rather, we now know that an incalculable number of difficulties, having their roots deep in the social structure of our cities, towns, and rural communities, enter into the problem. It was a comparatively simple matter in the beginning to make contact with the far-advanced case. When sanatorium care was available, he was removed from his home to prevent spreading his infection. But, there has proved to be much more than this to the

problem as knowledge has increased. Even among intelligent citizens, education, for the purpose of getting the early case spotted and under adequate treatment and for the persistent precaution against the spread of infection, is still an uphill process. Dealing with contacts has not been as simple a matter as was contemplated. Even the sanatorium patient did not always preach the doctrine of prevention taught him and unless carefully followed up he frequently succumbed to a relapse.

Poverty, and the shiftlessness and weakness of character that go hand in hand with it, still continue to be the most abundant sources of the disease. Certain industries have been found to create hazards and have a higher tuberculosis incidence among the employees than others. Everything that prevents normal development is grist for the tuberculosis mill. Bad housing, overwork, low wages, lack of recreation, and all poor conditions of personal, family, and community hygiene have their share in keeping the death rate up. There is a close correlation between economic stress—be it local or national—and the problem of tuberculosis.

When all is said and done, any movement that contributes in any way to the improvement of the general health of the people has a direct bearing on tuberculosis. That is why it is so imperative for the specialist in tuberculosis, physician or nurse to know and understand all phases of public health and to be keenly alive to anything in policy or administration which contributes or detracts from the possibility of eradicating this disease. It would be impossible in this article to do anything but

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mention one or two phases of public health that have a very definite influence on tuberculosis control.

You already know the danger to be found in an unprotected milk supply. Nurses of today will probably never see the crippling results of tuberculous bone conditions which so frequently came to light 20 to 30 years ago, mostly as a result of feeding children with milk from tuberculosis-infected cattle. Public health authorities attempt to have all cattle tested for tuberculosis and have all milk pasteurized. Nevertheless, in the face of this we know that even yet many children are getting dangerous or potentially dangerous milk. There is still education needed in this respect.

Another and more obscure contribution to the prevention of tuberculosis is found in the infant welfare programs. Rickets, once much more commonly found than today, is the result of poor feeding and unhygienic standards of living. Rickets in the infant means malnutrition and faulty bone development, including that of the chest, with an accompanying poor musculature. The rachitic child, because of his under-developed chest and other deficiencies, was a frequent subject for pneumonia and similar respiratory diseases. This increased his susceptibility and he became a potential, if not an actual victim of tuberculosis, perhaps not observed in childhood. Untreated, he carried his early infection into adolescence and adult life, helping to swell the ranks of those needing treatment for tuberculosis. Markedly improved methods of feeding infants are rapidly eliminating this type of individual.

Thus far I have attempted to prove that tuberculosis is bound into the warp and woof of our social order. In that respect it differs from any other disease, with the possible exception of the venereal diseases. For that very reason it presents to us a mighty challenge to which every trained nurse should be prepared, even in some small way, to respond. Every nurse, whether she is a public health nurse or not, is in a position,

by virtue of her training, to exert a powerful influence in the community where she lives and practises. She is able to observe more intelligently, understand more thoroughly, and even be the guiding hand in many situations. Perhaps the most important part of a tuberculosis program is the prevention and education that takes place outside the hospital. In this the public health nurse has a very important role, whether she be engaged in a generalized service or in a specialized one. In addition to being aware what the actual care of a tuberculous patient entails, she must understand every phase of the disease as it affects the individual, the family, and the community. Above all, she must be a teacher, a quality unfortunately lacking in many public health nurses because it is not part of their basic preparation. There are certain fundamental principles which the nurse must follow if she expects to get results in her work.

The main objectives of a good tuberculosis program are: case finding, case holding, case treatment, rehabilitation after treatment, and case prevention. The nurse has a positive place in the attainment of each of these objectives.

CASE FINDING

Every case of tuberculosis must be located, whether it is active, potential, or arrested, as well as all contacts and susceptible cases.

Methods: Surveys; cases reported to board of health; cases reported by physicians; cases discovered by nurses in the course of their work, as in bedside nursing, infant welfare, or school health supervision; cases seeking help as a result of a good educational program; contacts; cases discovered while seeking source of infection.

CARE AND SUPERVISION

This should be as follows:

To secure adequate medical and nursing care for all cases and to encourage and supervise their continued treatment.

To protect the family and community by teaching measures of prevention.

To secure periodic examination of

those already exposed to the infection, especially growing children.

To supervise the health of these contacts and pre-disposed cases and to build up resistance by promoting good health habits; securing for them the benefits of preventoria, open-air schools, or nutrition classes, if institutions are available, and to promote their establishment if not available.

To secure the correction of defects when these defects retard normal development.

To arrange with other available agencies for necessary social and economic adjustments. Where such community agencies are lacking, their establishment should be stimulated by the nurse.

To follow up and supervise discharged sanatorium patients to make sure they continue their health program, which should include periodic examination, and to assist them in obtaining proper and suitable work when necessary.

To keep records of all cases as an aid to the intelligent care of patients; as a basis for reports of service rendered; as a means of better cooperation with other agencies; as a guide to future plans; as a key to proper understanding of the local tuberculosis problems.

CASE PREVENTION AND EDUCATION

Stimulating the patient, the family, and the community to the proper attitudes towards tuberculosis may be done by teaching people, individually and in groups, the nature of the disease and the need for early diagnosis, the method of its transmission and the measures to prevent its spread.

To warn against the dangers of quack, non-scientific cures, and patent medicines.

To promote health measures, living conditions, and personal habits which will tend to build up the resistance of every member of the community.

To promote periodic health examinations for all.

In dealing with the individual case there are certain specific points which the nurse must know:

Is the patient an active case of tuberculosis? An arrested case? A suspect? Has he positive sputum? Has he had a complete examination? If not, why not?

Is he under definite medical care and whose? Is the case reported to the board of health?

Does the patient, or some responsible member of the family, know the true diagnosis of the disease? If not, why not?

How many contacts are in the home? Age and sex? Have they been examined? When? By whom?

Is the nursing care adequate?

Has the source of this infection been determined? If not, why not?

In securing the social history of the case, the nurse will need to know such things as:

Is the income adequate? If not, how can it be supplemented—by family, relatives, insurance, or by some organization? What other agencies are in touch with the case? Have they been consulted?

What other problems are outstanding in the family—diet, clothing, housing and sanitation, management, employment, neglect of children, attitude and cooperation.

As a measure of protection for the community the following information should be obtained:

Are precautions observed? If impossible to have them observed, has the board of health been notified? Have premises been cleaned after death or removal of a communicable case?

If the patient has left your district, has the health organization at the new address been notified?

Have all necessary information and work done on the case by the nurse been properly recorded?

Tuberculosis is a communicable disease—just as scarlet fever, diphtheria, and all the others are. Once the acute stage is over, and the patient has carried out the necessary treatment, *he is as free from germs as any normal individual*. This is a very important point, for it is only by breaking down and erasing that idea in the public's mind that we can rehabilitate the individual and have him again take his place in society. I feel this can only be done through education of the public, through our nurses' knowledge of the infectivity of the disease, and through literature. Every time a patient is diagnosed as an active case of tuberculosis always

bear in mind that he is ill mentally as well as physically.

1. He suffers from a disease people fear. He realizes this and it is a considerable shock to him.

2. He also realizes he has a disease which will keep him in bed for months—perhaps longer.

3. If he is married, he worries about his family financially. All these things tend to make him depressed and irritable, regardless of the fact he attempts to appear cheerful to those around him.

The nurse's work begins when a patient's condition is first diagnosed. We visit the home, advise the patient regarding treatment, teach precautions, and have all members of the family examined. If the case is a healed one or only suspicious we must look for the infector. This may not be in the immediate family at all, so it requires much tact and many channels for investigation. It may prove to be a neighbor, a relative, a fellow workman. Before we go outside to search we must first examine the immediate family.

It is very important to investigate the home conditions. If the patient is the bread-winner with a large

family, how can he go to bed or be hospitalized when his family has no means of support? This is a vital factor as he cannot stop working or worrying until the problem is solved. Such a family can be recommended for mother's allowance. If it is not enough, rent, food, and clothing must be provided. Welfare agencies should be called in to help.

Whether or not I have given you a bird's-eye view of the place of the nurse in this program of combatting tuberculosis, I shall not be able to tell. At least I can leave this one simple thought with you. There is a big gap between knowledge and practice in the present-day health habits of the people. Science in a few short years has changed our whole concept of health practices and has given us prevention and positive health as the goals toward which we now aim. People need constant teaching so that the gap may be closed. If we, as nurses, intelligently keep ourselves informed of each new preventive measure as it is accepted as sound and practical, and be prepared to pass on this knowledge, we will be doing our bit toward bridging this gap.

Health and Low-Temperature Environments

Dr. Jack C. Haldeman, of the U.S. Public Health Service, who is in charge of the Arctic Health Research Centre in Alaska, states that investigations have revealed numerous gaps in scientific knowledge of the effects of low-temperature environment on health. He pointed out, for example, that previously unknown foci of echinococcosis infection (a type of tapeworm in animals which causes frequently fatal cysts in man) have been discovered among both wild and domestic animals in Alaska.

This disease, Dr. Haldeman explained, assumes considerable public health significance in arctic environments in view of the

close association between human beings and animals, especially dogs, in cold areas.

Another significant development reported by Dr. Haldeman was the discovery of trichinosis among arctic marine mammals, such as whales, which are an important part of the diet in the coastal regions of Alaska. Dr. Haldeman said this problem had taken on additional emphasis with the further discovery of trichinosis among arctic carnivora.

Dr. Haldeman said that studies in human parasitology have revealed a high percentage of fish tapeworm among native residents in fish-eating areas. Further studies of this problem, he said, are scheduled.

Why does a pain "hurt"? The surface of the body is blanketed with millions of "pain spots" where pain nerves end. When any of these nerve endings is agitated or disturbed, it flashes a message to the brain. The brain then weighs this message, evaluates it in terms of so much pain.

Aux Infirmières Canadiennes-Françaises

Service Sociale des Groupes

SIMONE PARÉ

Average reading time — 24 min. 48 sec.

LE SERVICE SOCIAL comme profession est quelque chose de relativement nouveau. La première école de service social, celle de New-York, fut établie en 1898. Chacun sait pourtant que, bien avant cette époque et même depuis toujours, des bénévoles et des non-professionnels avaient recherché les moyens de diminuer la misère humaine, tant physique que morale, et avaient consacré à cette oeuvre toutes leurs énergies. L'ampleur de la tâche à accomplir, la nécessité d'une préparation scientifique pour bien l'accomplir, et l'avancement des sciences psychologique et sociologique donnèrent peu à peu naissance par la suite au service social professionnel. Il en fut certainement de même de l'évolution de la profession d'infirmière car les gardes-malades graduées, tout comme les travailleuses sociales diplômées, sont issues d'une longue lignée de pionniers bénévoles de la charité.

On a défini le service social moderne comme "l'art d'adapter l'homme à la société et la société à l'homme, ou l'art d'aider les autres à s'aider eux-mêmes." On a dit que le travailleur social était un technicien des relations humaines. Ces expressions semblent très justes. Il faut aider l'être humain à s'adapter psychologiquement aux personnes et aux conditions de vie qui l'entourent, de la même façon qu'il faut aider son corps à se protéger ou à réagir contre les agents nocifs qui en menacent l'équilibre physiologique. Il faut adapter la société et ses mul-

tiples rouages d'assistance et de sécurité aux besoins réels de l'homme, afin que cette société ne devienne pas en quelque sorte une immense machine déshumanisée qui broie celui qu'elle devrait secourir et assister, qui ne tient pas compte des réalités individuelles et familiales, et qui les détruit au lieu de les fortifier. Remarquons bien le respect de la dignité et de la liberté humaines impliqué dans le service social—"art d'aider les autres à s'aider eux-mêmes." Le client demeure toujours libre d'exécuter ou de ne pas exécuter les plans de réadaptation qu'il élabore avec le travailleur social. Celui-ci ne lui impose pas sa volonté mais le laisse prendre l'initiative et accomplir l'effort qui est la première condition d'un relèvement véritable et durable.

Le travailleur social moderne est préparé par des études de deux ou trois années dans des écoles universitaires appropriées qui sont au nombre de huit au Canada. On lui enseigne des techniques d'approche, d'observation, de réadaptation, de réhabilitation, basées principalement sur la psychologie, la psychiatrie, et la sociologie. On développe en lui une personnalité professionnelle comparable à celle qui distingue l'infirmière de la gardienne bénévole de malades—c'est-à-dire une facilité à utiliser consciemment et de façon responsable son moi professionnel, pour rendre les plus productives possibles les connaissances et les qualités acquises ou perfectionnées pendant les études professionnelles. On met le travailleur social à même de se servir de trois méthodes spéciales qui sont: celle du *service social personnel*, celle du *service social des groupes*, et celle de l'*organisation communautaire* en service social:

Mlle Paré, professeur à l'Ecole Sociale de l'Université Laval, Québec, a pris part au forum, intitulé "Aperçu sur le Service Social," à la 30ième assemblée annuelle de l'Association des Infirmières de la Province de Québec.

Le *service social personnel* traite individuellement la personne humaine, en travaillant aussi sur son milieu; le *service social des groupes* s'occupe d'aider les individus à s'adapter et à collaborer au sein de petits groupements de loisir, de culture, d'éducation populaire, d'étude ou de discussion; enfin, la méthode d'*organisation communautaire en service social* veut aider les groupes et les représentants de groupes à se partager les responsabilités d'une action collective et à en évaluer les résultats.

La méthode du service social personnel peut s'appliquer dans une multitude de champ d'action. On connaît le service social familial, le service social psychiatrique, le service social industriel, le service social scolaire, le service social des prisons et des cours de jeunes délinquants, etc.

Je vous parlerai moi-même de la méthode du service social des groupes, telle qu'elle pourrait s'appliquer auprès de certains types de malades et aussi auprès du personnel des hôpitaux à leurs heures de loisir.

Les énoncés que vous venez d'entendre vous ont permis de constater que le service social personnel tente de résoudre les problèmes des clients par une approche individuelle qui s'étend aussi au traitement du milieu.

La seconde méthode de la profession, celle du service social des groupes, emploie de son côté une approche à la fois individuelle et collective. Elle ne perd pas de vue la personnalité du client, mais elle invite celui-ci à se joindre à un milieu, à un groupe spécial, de récréation ou d'étude, où on pourra déceler les manifestations, les symptômes de ses mésadaptations et y remédier dans la mesure du possible, en l'aidant d'abord à établir de bonnes relations avec les autres membres du groupe et avec le travailleur social, puis à participer activement à la pensée et à la vie du groupe.

GROUPES EN GÉNÉRAL

D'abord pratiqué surtout dans le domaine de l'organisation des loisirs et de l'éducation populaire, le service social des groupes s'est aujourd'hui introduit dans les hôpitaux, les institutions pénales, les foyers pour enfants,

les hospices, les écoles publiques, les groupements d'infirmités, les associations religieuses, les mouvements de jeunesse, en un mot, partout où l'on croit à la valeur du groupe pour faciliter le développement social de l'individu et pour l'aider à mieux s'adapter à son milieu familial, à sa profession ou à son école, et à la vie civique.

Le service social des groupes est donc une méthode d'éducation qui poursuit deux buts distincts: d'abord, le développement personnel et l'adaptation de chaque membre du groupe; puis l'utilisation de l'association pour la poursuite de fins socialement désirables qui ont nécessité de la planification, une répartition des tâches, et une évaluation faites par le groupe. La poursuite de ces buts peut s'appliquer dans une situation concrète aussi simple que celle d'un groupe d'enfants réunis pour le jeu, tout comme dans un groupe d'adultes qui se sont donné pour objectif d'étudier et d'améliorer les conditions de vie de leur quartier ou de leur communauté. Dans l'une ou l'autre situation, il s'agit, pour le travailleur social, de créer entre lui-même et chaque membre une relation positive réelle, d'aider les gens à s'accepter et à s'adapter dans et par la vie du groupe, et d'orienter l'activité en apportant des suggestions, des idées, et en aidant les membres à canaliser, à enrichir, et à utiliser toutes les ressources venues d'eux-mêmes. Certains éléments nécessaires à l'application de la méthode apparaissent tout de suite:

Éléments d'homogénéité: Homogénéité d'âge, surtout dans les groupes de jeunes où existent des divisions bien tranchées; homogénéité d'intérêt pour les groupes d'adultes où l'âge devient un facteur moins important, dans cette longue période qu'on appelle la maturité.

Élément de stabilité: Tout travailleur social sait qu'un traitement efficace exige la régularité du client et, ici, chaque membre est en quelque sorte traité par sa relation suivie avec le travailleur social des groupes et aussi par la fréquentation assidue des mêmes personnes à l'intérieur du groupe. Ordinairement, un groupe se réunit chaque semaine.

Elément de limitation du nombre des membres: On sait par expérience qu'il ne s'établit pas de relation profonde et effective lorsque les membres d'une collectivité sont trop nombreux pour se bien connaître ou trop nombreux pour que le travailleur social puisse les bien connaître et les aider à établir de meilleures relations entre eux. Un groupe en service social compte généralement de 12 à 15 ou 20 membres à la fois.

Des connaissances psychologiques adéquates permettent au travailleur social des groupes de saisir les affinités qui font que des clients de tel âge peuvent former une collectivité qui fonctionnera heureusement, tandis que des membres plus âgés ou plus jeunes ne pourront pas s'y intégrer ou y être acceptés. Il est aussi possible, quand on connaît les besoins psychologiques correspondant à chaque période d'âge, d'orienter le programme du groupe de telle sorte que les intérêts des membres soient satisfaits par l'activité présentée. Il est bien important également de savoir que les enfants d'âge scolaire, qui satisfont leur besoin de socialisation dans les petites "gangs" ou bandes dont ils gardent jalousement les secrets, ont énormément d'ambivalence à l'égard des adultes et que le travailleur social, qui serait assez mal avisé pour s'opposer ouvertement aux chefs naturels de ces bandes ou pour contrecarrer systématiquement les opinions et les projets du groupe, serait voué d'avance à l'insuccès. L'approche des adolescents requiert aussi des aptitudes et un doigté bien particulier et le contact doit encore être effectué différemment si on a affaire à un groupe d'adultes ou de vieillards. Tour à tour substitut parental, idéal à imiter, ami professionnel, instructeur ou aviseur, le travailleur social doit maîtriser aisément ses attitudes et ses techniques s'il veut demeurer à la hauteur de sa tâche.

Remarquons qu'il ne s'agit pas là de groupes dont les membres présentent de véritables problèmes de personnalité, mais de réunions d'individus qu'on a convenu d'appeler normaux. Un enfant peut être considéré comme normal et rencontrer, à

cause d'une situation familiale particulière, des difficultés d'adaptation à ses petits voisins ou à ses camarades de classe qui lui rendront extrêmement utile, sinon nécessaire, la participation à l'activité d'un groupe et l'aide d'un travailleur social spécialisé. Un adulte peut éprouver encore les mêmes difficultés s'il n'a pas eu l'opportunité de triompher plus tôt des obstacles rencontrés dans le processus de sa socialisation. On découvrira peut-être que ses problèmes conjugaux ou professionnels proviennent d'un refus d'accepter les responsabilités ou de collaborer et il peut arriver que l'intégration active à un groupe fasse disparaître peu à peu ces lacunes. Enfin, disons que tout être humain, dans quelque condition qu'il se trouve, ne reçoit jamais la somme d'attention individuelle dont il aurait besoin et que la relation avec le travailleur social et avec les autres membres d'un groupe a souvent un effet significatif sur l'épanouissement d'une personnalité.

DANS LE MILIEU HOSPITALIER

Puisqu'il s'agit d'exposer ici les applications possibles de la méthode du service social des groupes dans le milieu hospitalier, disons qu'elle pourrait s'utiliser avec fruit auprès du personnel, pendant les heures de loisirs et, auprès des malades, dans certaines conditions spéciales.

Auprès du personnel, par exemple, auprès des aides si nombreuses employées dans les institutions hospitalières, le travailleur social des groupes agirait comme coordinateur et orienteur des activités de loisirs. Fidèle à son principe d'aider les gens à s'aider eux-mêmes, il mettrait en valeur les ressources du milieu, les talents et les aptitudes naturelles à la direction, pour transformer les périodes de loisirs non seulement en périodes d'amusement mais en véritables périodes d'éducation sociale, au cours desquelles se résoudraient peut-être plusieurs des problèmes de personnalité et d'adaptation qui expliquent les courtes durées d'emploi si fréquentes en ce domaine.

Auprès des malades, il suffit de se rappeler certaines caractéristiques psy-

chologiques de toute personne hospitalisée pendant un laps de temps appréciable, pour admettre les ressources précieuses que peut apporter le service social des groupes.

Nul n'est mieux placé que l'infirmière pour savoir que les meilleurs traitements médicaux ou chirurgicaux peuvent échouer quand le moral d'un patient, tel que le tuberculeux, le malade osseux, ou le névrotique, tend obstinément à se maintenir à un bas niveau.

L'amertume de l'isolement, l'impression d'être seul à souffrir de telle façon et à connaître tels problèmes, la peur secrète qui accompagne le désir de réintégrer la vie normale, sont des sentiments communs, souvent néfastes, à l'hospitalisé. On a si bien reconnu l'utilité de la méthode du service social des groupes pour contrebalancer ces fâcheuses influences que plusieurs institutions hospitalières, surtout américaines, ont invité un travailleur social des groupes à se joindre à l'équipe du médecin ou du psychiatre, de l'infirmière, et du travailleur social personnel, déjà mis au service des malades. Avec ses techniques d'approche individuelle et collective, distinctes des techniques de la récréation et de la thérapie par l'occupation, le travailleur social des groupes du milieu hospitalier a déjà à son actif de belles réalisations.

Dans un hôpital psychiatrique de Cleveland, un groupe de six malades mentaux—timides, déprimés, et complètement asociaux—se réunit une première fois pour un période de temps au cours de laquelle la travailleuse sociale ne réussit qu'à jouer individuellement une brève partie de dames avec deux d'entre eux. Après trois mois et demi d'efforts renouvelés chaque semaine, la travailleuse sociale put ramener suffisamment ces malades à la réalité et aux nécessités de la vie sociale, pour qu'ils collaborent avec enthousiasme dans la préparation de goûters et de programmes réguliers de détente. Elle avait réveillé leur confiance en eux-mêmes, leur intérêt pour une activité extérieure, leur capacité de se lier avec d'autres et d'acquiescer un certain esprit de corps.

Signalons aussi la valeur d'observation des dossiers hebdomadaires rédigés sur ce groupe, pour la poursuite du traitement psychiatrique auprès de chaque malade.

Un dossier provenant d'un hôpital de Pittsburgh rapporte, d'autre part, un intéressant travail de collaboration réalisé entre une travailleuse du service social personnel et une travailleuse sociale des groupes. Le client était un jeune vétéran, infirme d'une jambe et atteint de mélancolie évolutive. La coopération du malade avec le psychiatre et la travailleuse sociale psychiatrique ne fut rendue possible que par les visites répétées de la travailleuse sociale des groupes. Celle-ci, utilisant la passion et le talent du patient pour les cartes, réussit à le sortir peu à peu de sa dépression, en se faisant d'abord donner à elle-même des leçons de bridge, puis en créant, à l'aide du même prétexte, des contacts entre ce malade et d'autres hospitalisés. Après cinq mois de ce travail d'approche, le vétéran accepta enfin de causer avec le psychiatre et permit qu'on communiquât avec sa famille, afin de l'inviter à coopérer à son traitement.

Deux autres exemples, puisés dans les dossiers d'hôpitaux militaires, montrent le succès du service social des groupes auprès d'hospitalisés normaux au point de vue mental.

On mentionne un groupe de discussion que des blessés de guerre formèrent et utilisèrent, avec l'aide d'une travailleuse sociale, pour étudier et résoudre leurs problèmes de réadaptation à la vie civile. On cite aussi certains cas de chirurgie plastique, grands blessés de la face ou des membres, chez qui la participation aux discussions et à l'activité d'un groupe corrigea peu à peu des attitudes hostiles, déprimées, anxieuses, ou exagérément passives et irresponsables.

Le service social des groupes dans le milieu hospitalier est déjà une réalité vivante et bienfaisante chez nos voisins d'outre-quarante-cinquième. Il ne nous reste qu'à faire confiance à son idéal et à ses techniques pour l'introduire aussi efficacement chez nous.

Institutional Nursing

The New Look in Typhoid Fever

JEAN THIRLAWAY

Average reading time — 7 min. 12 sec.

WITH THE DISCOVERY of new antibiotics coming thick and fast upon us, I shall review the tremendous difference that one of these "wonder drugs" has made to the nursing care of typhoid fever. This drug is chloromycetin, prepared synthetically by a well-known drug house.

It has been used experimentally with surprisingly good results in the treatment of many diseases hitherto untouched by other antibiotics. Some of these diseases are: typhoid fever, pertussis, salmonella infections, bacillary urinary infections, undulant fever, and a group of diseases caused by the organisms known as rickettsia, notable among these being typhus fever and Rocky Mountain spotted fever.

Last summer, between June and September, we treated six cases of typhoid and paratyphoid fever and three of dysentery, caused by the *Shigella sonnei* bacillus, in our isolation unit with chloromycetin. Except for one child, who died two days after admission, the results have been very satisfactory.

On admission the stool or blood cultures of these children all showed evidence of *Eberthella typhosa*, the causative organism of typhoid fever; *S. paratyphosa*, the organism causing paratyphoid fever A; or *S. schottmuelleri*, causing paratyphoid B.

Although typhoid fever is a comparatively rare disease today, many of our nursing students graduating

without ever seeing it, the odd case still crops up, particularly during the summer months, in spite of preventive inoculations. This would seem to be due to either the prevalence of flies during this season, or to the tendency of people in their country homes, or children at camp, to be less careful in investigating the source of their water supply.

To those who nursed typhoid during the past decade or earlier, it presents a fairly grim picture. We saw acutely ill adults and children running a very high fever for a long period of time, resulting in delirium at first and later extreme emaciation. These people presented a real nursing problem. How often have we sponged them, trying to reduce their temperature, only to have it soar up again in a few hours' time! One remembers the constant vigilance for signs of perforation and hemorrhage; the endless hours of scrubbing and disinfecting and trying to feed nourishing fluids to these often semicomatose individuals.

This picture has completely changed with the advent of chloromycetin. Perhaps it would emphasize the difference to compare the treatment of a child of 15 in our hospital with typhoid fever in September, 1948, and the care that would be given one of approximately the same age today.

The first child was admitted on approximately the 11th day of disease. She was acutely ill, irrational, and showed evidence of having been ill for some time. Her blood and stool cultures were positive and she ran a fever of 105°-106° for a week, then a typical swinging fever for

Miss Thirlaway is head nurse on the isolation ward of the Children's Memorial Hospital, Montreal.

a week, gradually decreasing to normal around the 33rd day of disease.

Now consider the second child admitted this year. Again the temperature was high—104° on admission. From the history we gathered that he had been ill about two weeks at home. He was also dehydrated and acutely ill in appearance. Blood and stool cultures were taken which proved to be positive. In view of the history and symptoms, a tentative diagnosis of typhoid fever was made. The child was started on chloromycetin the night of admission.

His temperature remained around 103°-104° for four days, was swinging between 97° and 104° for only two days instead of a week, became normal within a week following admission and remained there until his discharge. The moderately severe diarrhea cleared up within a week. His appetite and general well-being were good within that length of time.

This child presented far fewer nursing problems than the first one. Due to his shortened stay in hospital much less scrubbing and disinfection were required. As he was only acutely ill for four and a half days following admission, he required less strenuous nursing care. As his appetite improved in the same length of time he was no feeding problem. He lost very little weight during his hospitalization.

The dosage of chloromycetin, as prescribed by the manufacturer's research workers, is 50 mg. per kilogram of body weight initially; then 250 mg. every two hours until the temperature is normal (approximately

three and a half days); then every three or four hours for a total course of eight to nine days' treatment. These dosages were initially advised for adults but we have used the same dosages for children with no evidence of toxicity. As this boy weighed 72 pounds on admission, the initial dose was 2,000 mg. We used eight of the capsules which are put up in the strength of 250 mg. per capsule. Thereafter one capsule was given every two hours.

As two of the patients so treated were small infants, the administration of the antibiotic presented a problem. The powder, when removed from the capsule, was extremely bitter to taste, so it was dissolved in the correct strength in a small amount of glucose and water solution and given to the infant by gavage.

The stool cultures from these children became negative very quickly and remained negative until the time when they were discharged.

The average length of stay in hospital was two to three weeks—quite a difference from the patients who used to stay two months!

The results of the treatment of typhoid fever by chloromycetin seem almost as dramatic as an old-fashioned pneumonia crisis and show a great deal of progress even in one year. Chloromycetin has certainly made the nursing care of typhoid fever a much lighter task. We hope that, in the near future, research workers may discover yet other diseases which react as readily to this drug as typhoid fever.

Nursing in Poland

A brief article in the *Information Bulletin for Red Cross Nurses* notes that the shortage of nurses in Poland is more acute than in any other country. Even before the war the number of nurses was not sufficient to meet the demand. During the war, for a period of five years, all nursing schools excepting one in Warsaw were closed. Since the war, 19 schools have been opened and graduate about 1,000 students a year. However, the increase in

hospital beds has far outpaced the growth in the number of graduate nurses. There are at present some 10,000 graduate and practical nurses.

The Polish Red Cross was commissioned to organize courses lasting six months for the training of more nurses' aides. Ten such courses were given during 1949. It is hoped the number will be doubled this year.

Chloromycetin Therapy

MARIAN M. DAVIES

Average reading time — 7 min. 48 sec.

THE INCIDENCE of typhoid fever today is occasional, indeed, and graduate nurses of the last few years have had very little experience in caring for the disease. Thus great interest was aroused over a recent case admitted to our hospital in which chloromycetin was included in the treatment.

A young woman, who was employed as a domestic, was admitted to hospital on May 11, 1950, with a history of general malaise and headache lasting for three weeks and an illness of increasing severity for 10 days prior to eventual collapse and subsequent admission to hospital. The initial diagnosis was "suspect typhoid."

The patient was admitted at 11:30 p.m., her chief complaints being acute abdominal pain, severe headache, pain in the lumbosacral area and nausea with vomiting. Admission temperature was 104.1°, pulse 140, respirations 38. Isolation precautions were taken until a diagnosis could be confirmed. The patient was sedated with phenobarbital sodium gr. 1½ and rested fairly well for six hours. At 6:00 a.m. she had a severe chill and the temperature dropped to 97.2°. At 8:00 a.m. it rose again to 102.2°.

Agglutination tests were made on May 12 and revealed: Typhoid "O" was plus 4 throughout to a dilution of 1/320 antigens. Typhoid "H", Paratyphoid "A" and "B", and *Brucella abortus* were all negative. The W.B.C. was 4,900.

On the basis of the agglutination tests and the W.B.C., and the fact that the patient had not been inoculated for a period of two years, a diagnosis of typhoid fever was made. Specimens of feces and urine were collected for culture and on May 16 *E. typhosa* was reported in both.

The patient was given 400,000 units of aqueous procaine penicillin on admission and triple sulpha gr. XV, q. 4 h.

These were discontinued upon a confirmation of the diagnosis and chloromycetin 250 mg. q. 6 h. was ordered and administered for 36 hours. As the patient did not respond sufficiently, the dose was increased to 750 mg. q. 4 h. for 18 doses and then reduced to 750 mg. q. 6 h. for six days; 250 mg. q. 6 h. was then given for six more days. Thus the patient received 39.75 grams of the drug in the course of treatment.

A febrile temperature, 102.2-105.3°, persisted for 72 hours after admission. Tepid sponges and alcohol rubs were given q. 3 h.; ice-cap was applied to the head. As the patient was very nauseated intravenous therapy of a 1,000 cc. of 5% glucose solution was given b.i.d. Turpentine stupes were applied to the abdomen. Morphine sulphate gr. 1/6 was used as a sedative and to reduce peristalsis. Forty-eight hours after admission the patient was able to retain fluids and thereafter bland high carbohydrate fluids were given ad lib.

After the increase in the dosage of chloromycetin the temperature began to subside and although a febrile temperature continued for 72 hours it ranged from 100-103.1°. On the 7th day at 4:00 a.m. the temperature was 99.3° rising to 101° at 4:00 p.m. and dropping to 99.1° at midnight. The only subsequent rise was on the afternoon of the 9th day to 99.1° and the afternoon of the 15th day to 99°.

Urinary retention developed 24 hours after admission necessitating catheterization every 4-6 hours. In view of this a retention catheter was used and released p.r.n. Normal saline bladder irrigations were done b.i.d. followed by an instillation of 4 cc. of a 1:1200 solution of silver nitrate. The catheter was removed after 96 hours and, although all mechanical means were employed to encourage the patient to void, catheterization and bladder irrigations had to be continued b.i.d. until the morning of the 17th day when the patient voided 2 oz. She was cath-

Miss Davies is medical supervisor at the Kelowna (B.C.) Hospital.

terized for residual urine. That evening she voided 17 oz. and had no further trouble.

Prior to reducing the dose of chloromycetin to 1 gram daily—i.e., 250 mg. q. 6 h.—agglutination tests were repeated. Typhoid "O" remained as before but Typhoid "H" was plus 2 in a dilution of 1/20 and 1/40 indicating that the patient was reaching the convalescent stage. Three consecutive specimens of feces, taken at this time, remained positive for *E. typhosa*.

At the conclusion of the administration of chloromycetin the agglutinations were again repeated. The only change was that the Typhoid "H" was plus 4 in a dilution of 1/20 and 1/40 and plus 2 in a 1/80 dilution. The Paratyphoid "B" was plus 2 in a 1/20 dilution. Three consecutive specimens of feces and urine were collected and all were negative. These were repeated at the end of four days and again were all negative. The agglutination tests taken at this time were unchanged from the last report.

A check of the R.B.C. and hemoglobin revealed a hypochromic anemia. The patient was given iron, fortified with liver and injections of thiamine hydrochloride, 200 mg. daily.

On the 15th day, daily, low tap-water

enemas were started and continued until natural evacuation was established. They were then given p.r.n.

Strict diet therapy was maintained throughout the hospitalization period. Bland and strained foods were given after the 4th day and the patient was encouraged to eat small amounts frequently. By the 16th day she was eating three meals a day with frequent added nourishment. As a result the weight loss was small. On the 16th day she was allowed out of bed and within a week was spending the greater part of the day up in a chair or walking about her ward. She was discharged on the 30th day.

General impressions gained from this case were: In view of the severity of the case and the time lag between the onset of the disease and subsequent medical consultation and diagnosis, the prognosis, in the opinion of the attending physician, would have been very doubtful had chloromycetin not been employed. The convalescent period was reached within two weeks, the total hospitalization period reduced by several weeks, and the patient's general condition upon discharge was good. Once again the antibiotics are conquering a scourge of the human race.

New Sulpha Drug Low in Toxicity

Successful use of gantrisin, a sulpha drug formerly called NU-445, in treating children is reported by Drs. John A. Bigler of the Children's Memorial Hospital, Chicago, and Orville Thomas of Shreveport, La., according to the Health League of Canada.

Good results were obtained in 55 children with pneumonia, bronchitis, tonsillitis, urinary

infection, and ear inflammation, the doctors say in the *American Journal of Diseases of Children*, published by the American Medical Association.

Gantrisin is low in toxicity, they point out. It also has the advantage of a high degree of solubility which assures that the drug will not crystallize in the body.

Health Progress

If we look back over this past half-century, we find five significant marks of Canada's health progress:

1. The general mortality rate has been reduced by one-third.
2. The average duration of human life has been extended by about 20 years.
3. The infant mortality rate is now less

than one-quarter of what it was.

4. The maternal mortality rate has been reduced by more than 60 per cent in the past 25 years alone.

5. There has been a general and impressive decline in the toll taken by the communicable diseases and the diseases of childhood.

—HON. PAUL MARTIN

Impressions of a New Graduate

TERRY POTVIN

Average reading time—3 min. 36 sec.

IN MOST schools for nurses, it is customary to have the members of the preliminary class write an essay on that ticklish subject, "Why Did You Come in Training?" I think it would be both interesting and enlightening to have the members of the graduating class also write an essay before they leave, this time entitling it, "Why Did You Stick it Through?"

While the little probationer stands on the threshold of something entirely new and exciting, her mind is filled with thoughts of a rosy future—a future of new learning, new friends, new ideals. The new graduate, too weary to stand, sits on her laurels, and looks back and remembers the day when she too stood expectantly before an open door and wondered what the future would bring. She remembers her first day in training, her first day on the floors, her first "hypo," her first "scrub," her first case-room delivery, her first death . . . and now, after three long years of daily repetition, these awesome "firsts" have become as second nature to her and she takes them all in her stride. But, through it all, she has managed to keep intact the ideal she had when, long ago, she wrote: "I came in training because I wanted to serve mankind" (or words to that effect). If she can still say, "I stuck it through because this is where I can best serve mankind," then, and then alone, is she worthy to be called a nurse.

You might say, "There are very

few girls nowadays who go in training with those ideals." I disagree! Though they don't always voice it as such, I think that 95 per cent of the young girls who enter a school of nursing have that thought deep down in their minds. They have the realization that they are about to embark on a career in which they can help others. If some few lose their ideals along the way, the nursing profession is not to blame. It is just that they were not made of "sterner stuff."

You read many articles about nurses in various magazines nowadays; many of them are not very flattering, others are downright insulting. But most of them show gross ignorance concerning the nursing profession. We've been accused of being hard and callous; we've been accused of being materialistic and money-minded . . . among many other things. Often I've heard such remarks as, "How can that nurse stand out there and laugh and smile when there's a patient dying in the next room?" If they only knew how much it takes for us to stand out there and smile and put on a cheerful front, they'd repeat, "How can they . . ." but they'd repeat it on a different note. We realize that there are people dying all around us every day, that there are people suffering and mourning loved ones; we realize it only too well. But it would be a sad state of affairs, indeed, if we all went around with long, sad faces, and I'd hate to read the comments that would be printed about us then!

I have gone off the track of the original topic of this article, which is supposed to be the impressions of

Miss Potvin graduated from St. Paul's Hospital, Vancouver, last year.

a graduating nurse; but these are many of the things which cross my mind at the moment and I'm sure that they are in the minds of many of my graduating friends. As I look back on the last three years of my life, I think, not of the disappointments, the hardships that have come my

way, but of the good it has done me and the good that, God helping, I may have done to others. And I wish to say to you who have yet to graduate: Enjoy your training and make the most of every moment of it for, as the saying goes, "You pass this way but once."

Nurses and Nutrition

L. B. PETT

Average reading time — 4 min. 48 sec.

YOU ARE WHAT YOU EAT

MAN CANNOT feel better or work harder than his food permits and the prime requisite from food is *enough food energy* to do the job. We measure this food energy in calories. In Europe, when coal-miners received an extra allowance of food, they could work a little longer at the needed coal production. This is a clear recognition of the need by industrial workers of enough calories to do their job.

Similarly, even in Canada, you sometimes find a need for calories that is not being met. If you skimp your food at one meal you have difficulty in making it up at the next. Thus, if you have a breakfast of a cup of coffee and no rest period with food in the middle of the morning, your work output after 11:00 a.m. may be very small and your errors and accidents are likely to increase.

Body-builders: After energy requirements are met you need *protein* for body repair and growth. This is necessary at all ages but the need for protein actually decreases in adults because they are not growing. Contrary to popular opinion, hard work has such a small effect on protein requirements that it is not necessary to increase the amount of meat, etc., for laborers. This is the purely physiological viewpoint but nutrition is concerned with the total mental and

physical health and working efficiency. From a psychological viewpoint, there may thus be a nutritional reason to increase the protein for heavy workers. Where you are dealing with adolescents who are still growing and also working, remind them to get lots of milk and meat.

Regulators: You have all heard about vitamins and minerals and the dramatic things that happen to the body when they are lacking in the food eaten. Although much has been said about vitamin B₁ for steady nerves and vitamin A and riboflavin for eyesight and other effects, I must warn you to remember that the prime requisite is just for food. Vitamins and minerals given to industrial populations, even in massive doses, have not yielded dramatic results from a work viewpoint. There are some exceptions where special conditions exist. The importance of salt for excessive perspiration should be mentioned. It is curious how people get trained and adapted so that less salt is needed. But it can never be neglected.

NUTRITION AMONG INDUSTRIAL WORKERS

No actual studies of the nutritional status of Canadian workers as a group have been carried out, but during the last several years various surveys have been made in Canada that indicate the probable situation. It must be said, first of all, that the better the income, the better the

Dr. Pett is chief of the Nutrition Division, Department of National Health and Welfare, Ottawa.

chance of everyone being well fed, but that undernourishment has been found at all income levels. Canadian studies have also shown undernourishment in families that were spending plenty of money on food. I have seen families spending twice as much money as in my own home but getting half as much nutritive value.

What then is the problem, if it is not alone a matter of money? The answer is that we are dealing with ignorance of food values and indifference to the importance of food to health. This is where the nurse is a most important person. You have heard how the nurse, especially in industry, has to be everything from a first-aidster to a psychiatrist, so I have no hesitation in saying that you should also do some nutrition work.

But I wonder if anyone has ever told you *why* nurses have such a key position? The answer is simple. You have a direct contact with the *people concerned* and such a direct contact is far more valuable than any form of propaganda yet devised. Let me cite two examples to prove this because it has been experimentally tested.

The first is taken from Lucy Gillett's book "Nutrition in Public Health," which is almost the only text in this field that is really written for nurses. Over a nine-month period, ordinary propaganda methods on the use of more milk raised the consumption only 1 per cent. With a different group, a personal discussion of milk with each individual raised the amount used in nine months by 30 per cent. The same individual attention in connection with using vegetables doubled the consumption in the same period.

The other example is an experiment during the recent war. A group of piece-work employees were being given special attention in all phases of industrial hygiene. The lighting facilities were improved and work output increased. Of course the lighting engineers smiled and said, "There, we told you so." But then someone fixed up the chairs and again the output increased. Then they gave the girls a mid-morning rest period and again the output increased. When they gave some food and the work increased,

the nutritionists smiled and said, "We knew it all the time."

But then some mean person decided to be scientific about this test. They withdrew the food at the rest period. They cancelled the rest period. They gave back the old chairs and old lights. What happened? The work output went up again to an all-time peak. Why? The girls entered into the game enthusiastically because they were pleased at getting so much personal attention from the management. This is not an argument against any of these reforms. It is an indication of the psychological effect of personal attention. That is the kind of attention that nurses can and do give.

WHAT TO DO

Of course you have to know what to do and what to eat but I can't begin to tell you all this here. You should know about *Canada's Food Rules*. You can get these in any quantity desired. By handing them personally to someone they will get better attention. They are the best advice we can give on what to eat for health—it is the variety that is the important thing.

Then you may want to encourage better lunch-pails by giving individually where needed a copy of *The Lunch Box*.

If there is a cafeteria where you work you can talk to the waitresses and give them a copy of *If You Serve Food*.

CONCLUSIONS

1. Remember that enough food (calories) is the first essential.
2. Proteins and vitamins and minerals have some importance but only rarely can they make a specific contribution, other than in the value of good eating habits.
3. The personal approach is of more value than a lot of posters, leaflets, etc., scattered around.
4. You can get our material from any Provincial Health Department or you can write me in Ottawa.
5. You must be convinced yourself, enough to be a good example, in order to be effective. Try out the Score Sheet.

Nursing Profiles

Jenny M. Weir has been appointed director of the School of Nursing of Queen's University, Kingston, Ont., where for the past three years she has been lecturer and, more recently, acting director.

Born in Wilmer, B.C., of Scottish descent, Miss Weir completed her high school course in Invermere, B.C. She graduated from the University of Alberta Hospital, completing the requirements for her U. of A. bachelor of science degree at the University of British Columbia, majoring in public health nursing. She also holds her M.A. from Teachers College, Columbia University, where she specialized in supervision in public health nursing.

Miss Weir joined the staff of the Metropolitan Health Committee, Vancouver, in 1941. Three years later she resigned to enlist with the nursing service of the Royal Canadian Air Force. She was with this service until her discharge in 1946. An eager student, Miss Weir is continually on the alert for new avenues to explore in her chosen field. She is an accomplished musician, loves dancing and swimming.



Krass Studio

JENNY WEIR

Rhea (McRae) Whitty is with the Nurse Registration Branch of the Ontario Department of Health where she is responsible for the inspection and supervision of the nurs-

ing assistants. Mrs. Whitty graduated from St. Joseph's Hospital, London, in 1939, receiving her certificate as an instructor in nursing the following year from the University of Western Ontario. Married in 1940, Mrs. Whitty engaged in private nursing for several years. She returned to floor duty in the obstetrics department at St. Joseph's Hospital, Hamilton, in 1946, but soon moved on to become chief instructor with the Nursing Assistants' Training Centre in Hamilton. In the fall of 1948 she moved to Brantford where she was social worker in the Family Service Department of Brant County Children's Aid Society until she accepted her present position.

Lola Wilson assumed full responsibility for the duties of secretary-registrar and school of nursing adviser with the Saskatchewan Registered Nurses' Association last June. A graduate of the University of Toronto School of Nursing in 1943, Miss Wilson engaged in both private nursing and staff work in hospitals before enrolling for the certificate course in school of nursing administration at the University of Alberta. She served for a time as nursing arts instructor and clinical supervisor at Dauphin (Man.) General Hospital and was also the superintendent and health director at the Jewish Children's Home



LOLA WILSON

and Aid Society of Western Canada in Winnipeg. After several months' experience as assistant registrar, Miss Wilson is thoroughly familiar with the numerous ramifications of the work with this vigorous, growing association. We wish her well in her new responsibilities.

Dorothy Morgan is now assistant superintendent at St. Barnabas Hospital, Minneapolis, having been the first Canadian woman to graduate with her Master of Business Administration degree from the University of Chicago. A graduate in nursing administration from the University of Western Ontario, Miss Morgan served for four years as assistant superintendent of nurses at the Kingston General Hospital. During her term as chairman of District 7, R.N.A.O., she acted as a consultant when the Ontario program for nursing assistants was set up.

Major Doris Martha Barr is the superintendent of Grace Hospital, Windsor, Ont. Born at Dawson City of Scottish parentage, Major Barr graduated from the Salvation Army College in 1922 and enrolled at once as a student nurse in the hospital where she is now in charge. Upon graduation in 1925, she served for two years as night supervisor in Grace Hospital, Halifax. Transferred to Grace Hospital, Ottawa, she was operating room supervisor for two years then superintendent of nurses for three. In 1932 Major Barr became superintendent of nurses at Grace Hospital, Winnipeg. She accompanied her father, the late Commissioner Barr, on his last appointment before retiring—that of Territorial Commissioner for Korea. During the 18 months of her stay in Seoul, Major Barr was active in nursing. On her return to Canada in 1938, she was appointed superintendent of nurses at Grace Hospital, Windsor. She is currently a member of the Board of Directors of the Ontario Hospital Association.

Helen Louise Potts has been appointed supervisor of nurses at Sarnia General Hospital to assist Rahno Beamish who has combined these duties with those of superintendent of the hospital for the past five years. A graduate in 1918 of the Brantford General Hospital, Miss Potts had retired in 1948 after serving for 17 years as the superintendent of the Woodstock General Hospital, Ont. Previous to that, she had held positions of responsibility in Ohio, California, and at



Josephine Smith, Windsor, Ont.

DORIS BARR

the Brantford General Hospital. Miss Potts has recently been a member of a committee set up to study the needs of Ontario hospitals.

Kathleen Rose Escott is now the assistant superintendent of nurses and instructor in nursing education at the Manitoba Sanatorium, Ninette. Miss Escott has a unique background and very broad experience for her new work. In 1925 she joined the staff at Ninette as a nursing assistant. Seven years later she transferred to the Central Tuberculosis Clinic in Winnipeg. In 1938 she went to the staff of Dynevor Indian Hospital, Selkirk. Miss Escott enlisted as a hospital



Davidson, Winnipeg

KATHLEEN ESCOTT

*John Palmer***ETHEL M. BARRETT**

assistant (sergeant) with the R.C.A.F. in 1942 for service in Canada. In 1945 she was sent over to Britain by the St. John Ambulance Brigade in which she has been interested and active for many years. Upon her return to Canada in 1947, Miss Escott decided it was time she either got right into professional nursing or got out of it altogether. Courageous woman! After over 20 years of activity in the minor rank of nursing service, she was admitted as a student in Grace Hospital, Winnipeg, graduating as a full-fledged registered nurse this year. It was a tribute to Miss Escott that she was immediately appointed to her present position.

Berthe Therrien has been named local supervisor at the Frontenac office of the Metropolitan Life Insurance Company nursing service in Montreal. Graduating in 1927

from Hotel-Dieu, Montreal, Miss Therrien engaged in private nursing for two years, then joined the staff of the M.L.I.C. She has served with them for four years in Sherbrooke, one year in Sudbury, and the rest of the time in Montreal. In 1937, Miss Therrien received her certificate in public health nursing from the University of Montreal. She has also taken some work at the University of Michigan.

Ethel M. Barrett, who joined the staff of the medical department of the Bell Telephone Company in Toronto in 1927, has recently been appointed supervising nurse there. In her new capacity she will assist with the supervision of the nursing staffs in the various offices of the company.

Evelyn Wales has retired after 18 years of devoted service as school nurse in Verdun, Que. Graduating from the Montreal General Hospital in 1916, Miss Wales engaged in private nursing until 1930. That year she was awarded the Flora Madeline Shaw Memorial Scholarship and enrolled with the McGill School for Graduate Nurses, receiving her certificate in public health nursing the following year. She was appointed in 1932 to the position she has just vacated. In addition to some personal gifts, the citizens of Verdun raised money for a special scholarship fund, to be named in her honor, which will benefit the boys and girls of the community in which she has labored so faithfully.

Nurses' Prayer

Give me a body strong to serve,
A mind alert to learn,
Give me a heart that understands,
A soul where visions burn.

For every one by day or night
Guide me to do my best,
And grant me skill and courage, too,
In meeting every test.

Help me to love and work without
One selfish thought for me,
So shall I be a minister
Of healing, Lord, with Thee.

Give to my smile and voice Thy grace
Of warm serenity
To soothe my patients' fears and help
Them trust in me and Thee.

Oh give me words to comfort, Lord,
Like candles, in the night.
Teach me the need of little things
To heal and bring delight.

—*The Glad Tidings*

Lyle Creelman *Writes . . .*

Average reading time — 4 min. 24 sec.

“WE NEED MORE NURSES” is the cry which comes from all parts of the world. You hear it every day in Canada. In your daily work you see so much that is to be done that the need is very real to you. But how would you like to be one of fewer than 1,000 qualified nurses in a country of 19,000,000 people? If you went to Egypt that is the situation you would find. You would also be in frequent contact with disease conditions that are non-existent or rare at home, such as bilharzia—which infects over 12,000,000 of the total population—rabies, trachoma, malaria, extreme malnutrition, diphtheria, and many others. Added to this, there is an acute shortage of hospital beds, not enough personnel to staff those they have and, because of the ever-present need to provide treatment facilities, there is no staff, and even less time, to develop preventive health programs based on sound health education methods. The real need for such programs is indicated by an infant mortality rate of 142-160. In some places, we were told, it is even as high as 400.

In Egypt, as in most of the Middle and Far Eastern centres, midwifery has a much better status than nursing. Every girl who starts out to be a nurse has the ultimate objective of becoming a midwife or *hakima*. Indeed the program of the school of nursing has been planned to make this almost automatic. To say “the” school of nursing is correct, since until about a year ago there was only one school recognized by the Government—the Kasr-el-Ainy in Cairo.

The origin of this school is very interesting. In 1847 Clot Bey wanted to start a school of midwifery. In order to obtain applicants he had to buy ten Abyssinian and Sudanese girls from the slave market. He took as well two eunuchs from the Viceroy's palace. At the time of our visit,

this school had about 400 students. They have their experience in three hospitals, the largest of which is Fouad the First. This hospital has over 1,400 beds for medical and gynecological cases and an out-patient department with a daily patient average of 5,000. The nursing staff for this whole hospital consists of 90 qualified nurses and 173 students.

You can well imagine how impossible it would be to give the professional nursing care required by ill patients. The training period consists of two and a half months of preliminary school, followed by a three-year period during which experience is obtained in nearly all the fields but obstetrics. At the end of this time the nurse is given a diploma. She remains in the hospital for one year of practical work, following which she takes a year's midwifery course. This means that she spends over five years before she becomes a qualified nurse-midwife. Nearly all the lectures are given by doctors. As there are no nursing texts in the Arabic language, the



At an Egyptian health centre. Note how the mother carries her baby.

general pattern is to dictate the lectures and have the students copy the notes.

You would be shocked if you were to enter some of the children's hospitals in Egypt. Usually the mother is admitted with the child and, because of shortage of space, she may occupy the same bed. Very frequently she may have to bring one or more of the children from home because there is no one to look after them. In actual fact, the mother is the one who gives the nursing care to the ill child. From the emotional and educational point of view this system has many merits. In maternity hospitals the baby may be in bed with the mother but is usually in a bassinette at the foot of the bed. This more nearly approaches the modern "rooming-in" idea that we are accustomed to in many Canadian hospitals.

There has been a course for public health nurses since 1934 but a very limited number have been prepared. Since it would be necessary to spend an additional year beyond the five years she has already spent in a preparation which is largely an apprenticeship, it is not to be wondered at that the nurse is not anxious to take an additional course. In the public health field the nurses work in rural health centres which have been established all over Egypt or in the child welfare centres which perform a similar function in the cities. Usually the nurse in charge is a *hakima*. In the majority of cases, she has not had any public health preparation.

These centres are quite unlike our

child health conferences in that the mothers come very early in the morning, sometimes shortly after seven o'clock, and frequently they must wait patiently for hours to be seen by the nurse; few can be seen by the doctor. Nearly all have come for treatment. In the summer it is routine to give eye treatment for conjunctivitis to practically all who attend. In some of the centres there may be a daily attendance of 200-300. Here also will be assistant midwives who have been given one year's preparation. Most of the mothers are delivered at home with the aid of this assistant group or perhaps midwives with even less preparation.

This brief glimpse indicates the many serious problems facing those who are interested in the development of a profession, adequate in numbers and preparation, to give the nursing service the community requires. Because nursing today in this, as in fact in nearly every country, is very largely an apprenticeship, the relatively few girls who finish high school in Egypt prefer to go into the professions of teaching, law, social work, or medicine. Every effort must be made to improve the status of nursing. It was my feeling that one of the first things that must be done is to establish a demonstration school on a truly educational basis. Certainly this would not relieve the shortage of nurses in a hurry but it would do more than any other thing to attract the better educated girl and to show that nursing is really a worthwhile and satisfying career.

Expansion in Saskatchewan

To help improve public health services in Saskatchewan the Federal Government has agreed to underwrite the salaries of 20 additional public health nurses, Hon. Paul Martin, Minister of National Health and Welfare, has stated. The extra nurses are being recruited as rapidly as possible. Three will be assigned to the Swift Current health region, one to Assiniboia, two to Weyburn,

two to Moose Jaw, three to North Battleford, and nine to districts outside established health regions.

The addition of nine nurses to the staff of the health districts will provide much more adequate coverage, Mr. Martin pointed out, as the ratio of public health nurses to population in these districts at the present time is one to 25,000.

Trends in Nursing

Average reading time — 5 min. 48 sec.

Canada

HAVE YOU READ "Food for Thought" lately? If not, you should take time to read the May issue. September is here and you will be planning your activities for the winter. This little 64-page book contains a wealth of information about the Canadian way of life and the development of the Arts. Achievements of some of Canada's more gifted children are noted and you may find here the spur you need to take the step into a fuller life. (Published by the Canadian Association for Adult Education, 340 Jarvis St., Toronto 5.)

Another Milestone

Only two years ago, the contribution of *Nursing* to the problem of world health was almost ignored. Now, due to the ceaseless activities of the I.C.N., the subject of *Nursing* occupied an important place in the crowded agenda of the Third Assembly of the World Health Organization. Miss O. Baggallay, acting chief, Nursing Section, presented the "Program Proposed for 1951" and the "Report of the First Session of the Expert Committee on Nursing," saying that nursing is an integral part of the other parts of WHO. Miss Daisy Bridges, R.R.C., executive secretary, I.C.N., opened the discussion by recalling statements made in the report as follows: "Nurses are the final agents of health services. Nursing is essential to the vitalization of the health program. . . In countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine." Miss Bridges then referred briefly to specific recommendations:

1. The Expert Committee recommends that there be a joint investigation with

the International Labor Organization into working conditions of nursing personnel and suggests that the assistance of the I.C.N. should be sought in carrying out this investigation. This subject is already being studied in part by our Economic Welfare Committee and the findings of our committee might serve as a basis on which the fuller investigation, as well as the pilot study which is envisaged, might build.

2. The Expert Committee suggests that the I.C.N. continue its work in the development of a guide to schools working to establish basic programs. Our Education Committee has this in hand and is at present engaged on a study of how to improve the supply of visual aids in the teaching of nurses.

3. The Expert Committee recommends that the I.C.N. make a study of available programs in post-basic nursing education throughout the world and continue its work on a guide for the development of post-basic programs.

Miss Bridges closed with the reminder that, while the I.C.N. was most desirous to cooperate in implementing this Report and would accept responsibilities and do everything to implement them, the financial position of the I.C.N. would make it necessary to seek some form of financial assistance. Lively discussion followed and the following resolutions were unanimously carried:

1. The Third World Health Assembly approves the program proposed for 1951; accepts the views of the Expert Committee on Nursing that developing health programs call for measures to increase and improve the supply of nurses of all types and for better use of the supply; stresses that programs of nursing education should be so planned that all nurses are given an understanding of the social and preventive aspects of modern health work; requests the Executive Board and the Director-General to take into consideration the views expressed on this subject by the Committee on Program

when implementing the program.

2. The Third World Health Assembly notes the Report of the Expert Committee on Nursing; expresses its gratitude to the Committee for its work; requests the Executive Board and the Director-General to take into account the recommendations in the Report in so far as they may be applicable when implementing the program.

—*Nursing Mirror*, May 26, 1950

Developments in Allied Fields

Mental care pilot program: A contract between Roosevelt Hospital and the State Department of Mental Health was signed April 5, marking the start of a pilot program for treating psychiatric patients at the hospital. Roosevelt Hospital and Ellis Hospital in Schenectady are the two institutions selected for a new program that for the first time in New York State's history will permit its funds to go to general hospitals for psychiatric service. The program is designed to reduce the number of chronic patients in state mental hospitals through preventive medicine and to provide psychiatric care for persons whose conditions are not sufficiently serious to require hospitalization for more than a few weeks. The hospital plans a training program for resident doctors also. There will be one full-time resident doctor on psychiatry and each resident in the hospital will spend part of his training time with the psychiatric service. This will increase his knowledge of psychiatric treatment and give him experience to diagnose psychiatric components in patients in his own specialty.

Dentists use tests: Aptitude tests will be required of nearly all applicants to schools of dentistry under a program announced by the American Dental Association. Forty of the nation's 41 dental schools have asked to be included in the program, designed to serve as an aid in selecting the best qualified and most promising students among the applicants. After individuals apply for entrance as dental students, the schools will

screen the applications and forward the remaining names to the ADA. The association in turn will notify the applicants of the time and place for the aptitude tests. Results of the tests will be forwarded to the schools and will be considered, along with other information, in making a final evaluation of each applicant's suitability as a dental student.

Prepaid medical plans: The remarkable successes scored by the Blue Cross and Blue Shield Plans have shifted the health insurance limelight from the stale-mated political front to the active and critically important economic front. In scores of cities the economics of medical practice are being reshaped to the needs of the times by a creative community effort—voluntary, democratic, and realistic. That is the new history-making economic front of the voluntary health plans . . . Nevertheless the doctors have no great cause either for jubilation or optimism. The fact is that the medical service plans are lagging behind the hospital service plans. Blue Shield has nothing to show that is in any sense comparable to the recent Blue Cross contract with the steel industry. The Blue Cross steel industry contract provides about 900,000 people—employees and their dependents—with uniform hospital benefits at uniform rates on a coast-to-coast basis, the cost shared by management and labor. Blue Shield is being left behind because in most cases it is simply not offering the people the program they want. Both management and labor complain that they are finding the Blue Shield offerings unrealistic. The people want medical care—not just hospitalization. Voluntary hospital service alone will not lick the compulsory health insurance bill.

Responsibility for uniform benefits at uniform fees, responsibility for a realistic approach to fees so that premiums can be kept within the reach of the wage, responsibility for a realistic attitude toward every segment of the community involved in the building of the medical service plans—these are the three major

responsibilities the doctors must make theirs if Blue Shield is to come into its own.

Medical care for workers: Through legislation, judicial review, and voluntary and administrative action, an intricate and complex system has developed to ensure disabled workers of both financial compensation and medical care for work injuries and occupational illnesses. Under medical care provided by the Workmen's Compensation Law, disabled workers in New York State have a "free

choice" of physician, provided the physician is one of the 25,000 doctors in the state who are authorized to render care in one or more of 28 medical and surgical specialties. Under a "free choice" of physician, the board is developing a program of bringing together the injured worker's physician and the latest techniques for intensive physical rehabilitation, now available in a number of medical centres throughout the state.

—*Public Health Economics*,
May, 1950.

Orientation et Tendances en Nursing

LE CANADA

Avez-vous trouvé votre passe-temps favori? Si non, nous vous conseillons de lire le bulletin publié par l'Association canadienne de l'Education des Adultes, numéro de mai (340 rue Jarvis, Toronto 5). Ce livret de 64 pages contient une foule de renseignements concernant le Canada—la façon de vivre de ses habitants, le développement des arts, etc. Les succès de quelques-uns de ses enfants les mieux partagés y sont mentionnés; peut-être que la lecture de ces pages vous donnera un élan vers une vie plus remplie et plus intéressante.

UN AUTRE ECHELON

Il y a deux ans lorsque les problèmes de santé du monde étaient considérés, les infirmières étaient à peu près ignorées. Maintenant, grâce au travail incessant du Conseil International des Infirmières, la question du nursing occupe une place importante dans l'ordre du jour de la troisième assemblée de l'Organisation Mondiale de Santé.

Mlle O. Baggallay, directrice intérimaire de la Section du Nursing, a présenté "Un Programme pour 1951" et le rapport de la première réunion d'un Comité des Experts en la matière.

On lit entre autre dans ce rapport "que le nursing est une partie intégrale des activités de l'O.M.S. Les infirmières, en dernières mains, sont les agents des services de santé. —Le nursing semble d'une importance vitale à tout programme de santé.—Dans les pays

où la médecine est très avancée et le nursing ne l'est pas, l'état de santé du peuple n'est pas à la hauteur du développement de la médecine."

Ces assertions de Mlle D. Bridges, secrétaire exécutive, C.I.I., ont donné lieu à plusieurs recommandations:

1. Qu'une enquête soit faite sur les conditions de travail du personnel hospitalier.
2. La suggestion que le C.I.I. continue à préparer un guide à l'usage des écoles d'infirmières.
3. Qu'une étude soit faite par le C.I.I. des programmes des cours post-scolaire (cours de base) existant dans les divers pays et qu'un guide soit préparé afin d'assurer le développement de ces cours.

L'O.M.S. approuva, lors de sa troisième assemblée, le programme proposé par le Comité des Experts en Nursing pour 1951. Les vues suivantes furent acceptées:

Si l'on veut établir et développer des programmes de santé, il faut augmenter le recrutement du personnel infirmier de toutes catégories et n'employer ce personnel qu'à bonne fin.

Le programme d'études dans les écoles d'infirmières devrait être préparé de façon à faire comprendre à toutes les infirmières les aspects de la médecine sociale et préventive.
—*Nursing Mirror*, le 26 mai, 1950.

DU NOUVEAU EN PSYCHIATRIE

Un contrat entre l'Hôpital Roosevelt et le Département de l'Hygiène Mentale de l'Etat

de New-York servira d'étude témoin dans un nouveau mode de traitement des malades psychiatriques. Pour la première fois dans son histoire, l'Etat de New-York va payer les frais d'un service de psychiatrie dans un hôpital général.

Ce programme de médecine préventive a pour but de diminuer le nombre de malades chroniques dans les asiles d'aliénés. L'on croit qu'en admettant dans des hôpitaux généraux pour traitement psychiatrique, les malades qui ne requièrent que quelques semaines d'hospitalisation, l'on arrivera à ce but.

L'hôpital emploiera dans ce service un psychiatre à temps complet et les internes y feront un stage comme dans les autres services; afin de leur permettre d'acquérir certaines connaissances au point de vue diagnostic et traitement qui leur seront utiles en clientèle.

AVEZ-VOUS PEUR DU DENTISTE?

Toutes vos craintes doivent être du domaine du passé. Les dentistes maintenant doivent passer des tests d'aptitudes en faisant leur demande aux facultés dentaires. Voilà le programme annoncé par l'American Dental Association. Quarante écoles sur un total de 41 vont appliquer les tests afin de choisir les candidats les mieux qualifiés.

ASSURANCE D'HOSPITALISATION

Le succès remarquable obtenu par les plans d'assurances offerts par la Croix Bleue et par Blue Shield a rejeté dans l'ombre les projets d'assurance-santé de l'Etat. Si l'on en parle encore, ce n'est pas tant au point de vue politique qu'au point de vue économique où elles sont l'objet d'une grande critique.

Dans bien des villes, la pratique médicale a été réorganisée de façon à répondre aux besoins économiques actuels. Grâce aux efforts conjoints des citoyens l'on a offert des plans pratiques, démocratiques, et volontaires. C'est l'histoire des assurances d'hospitalisation volontaire.

Néanmoins, cela n'a pas donné aux médecins

l'occasion de se réjouir ni d'être trop optimistes. Les plans d'assurances couvrants les honoraires des médecins et des chirurgiens ne sont pas comparables et n'offrent pas les avantages des assurances d'hospitalisation.

La Croix Bleue (assurance d'hospitalisation) a signé un contrat avec les industries de l'acier par lequel elle assure à 900,000 personnes et à leurs dépendants l'hospitalisation en maladie à un taux uniforme pour employeurs et employés par tout le pays. Le Blue Shield (assurance couvrant les honoraires des médecins) n'a rien de comparable à présenter tout simplement parce que dans bien des cas leurs plans d'assurance ne conviennent pas aux gens à qui ils sont offerts.

Les patrons comme les employés se plaignent que les plans offerts par Blue Shield ne sont pas pratiques. Néanmoins, les gens désirent avoir une assurance incluant les honoraires des médecins. Si la population désire des assurances-santé et si ces assurances doivent demeurer volontaires les médecins doivent faire face à de grandes responsabilités.

La prime doit être pratiquement abordable pour tous les salaires. Elle doit être la même pour tous et les services doivent répondre aux besoins du groupe intéressé. Les assurances volontaires d'hospitalisation ne seront pas suffisantes pour empêcher l'établissement des assurances-santé obligatoires.

—*Public Health Economics*

MALADIES ET ACCIDENTS DU TRAVAIL

Grâce à des lois, à l'action volontaire d'administrateurs, les travailleurs bénéficient de certaines indemnités en cas de maladies et d'accidents. D'après la loi des accidents du travail de l'Etat de New-York, les invalides seront libres de choisir leur médecin, en autant qu'il sera l'un des 25,000 médecins autorisés dans l'Etat à donner des soins spécialisés en médecine et en chirurgie.

L'on veut par ce moyen amener le médecin et le travailleur à utiliser les ressources offertes par les centres de réhabilitation où les meilleures techniques sont employées.

Recognition and treatment of crippling conditions are needed early in childhood to prevent feelings of inadequacy and emotional conflicts and to help avoid difficulties in school that result in the repetition of

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¹Kraemer, M.: Postgrad. Med. 2:431 (Dec.) 1947.

²Kraemer, M., and Siegel, L.H.: Arch. Surg. 56:318 (March) 1948.

³Martin, G. J., and Wilkinson, J.: Gastroenterology 6:315 (Apr.) 1946.



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CANADA

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1950



THE CANADIAN NURSE

POLIOMYELITIS

A. McCarthy

WORK CONFERENCE
REPORTS



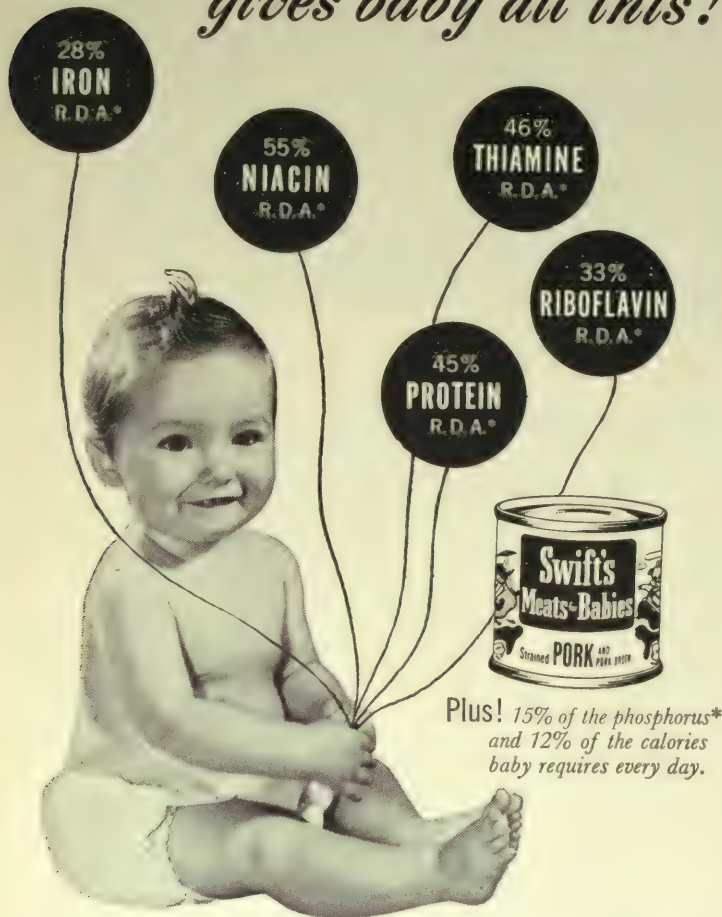
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Photo by Lillian Wooding, R.N.



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REPORT No. 5

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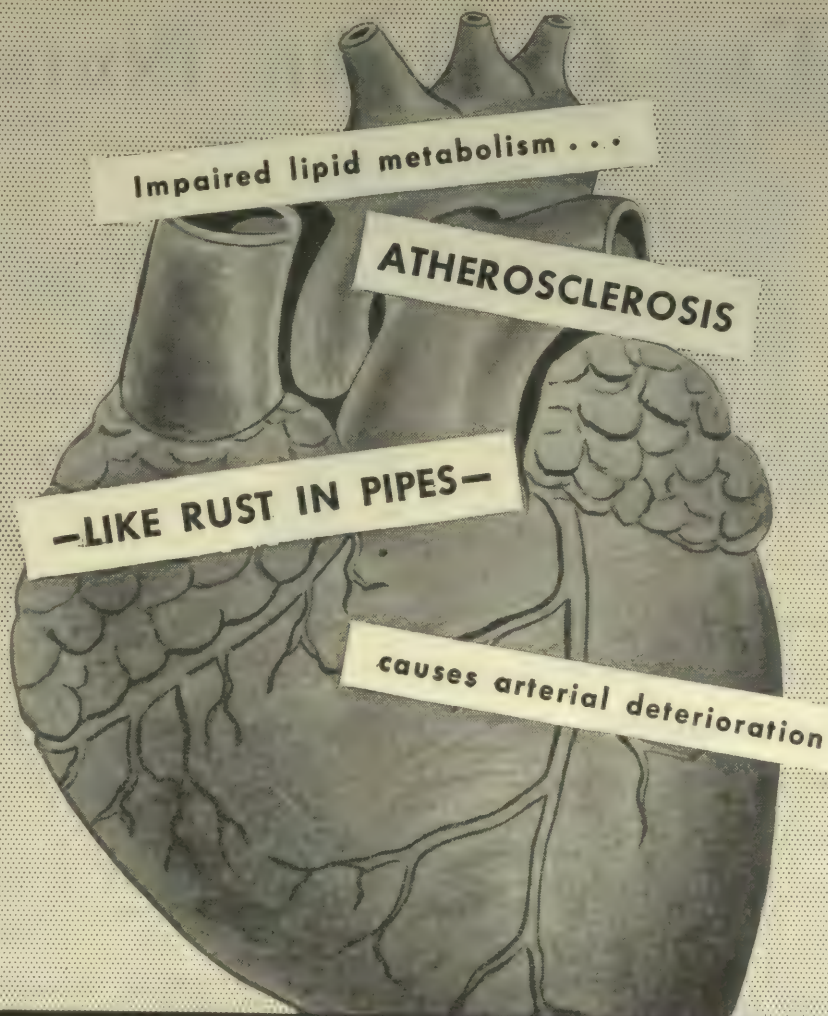


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The Canadian Nurse

VOLUME 46

NUMBER 10

OCTOBER, 1950

NEW PRODUCTS.....	782
PRIDE TEMPERED BY HUMILITY.....	<i>H. G. McArthur</i> 789
RECOVERY ROOM.....	<i>H. R. Griffith, M.D.</i> 791
ACUTE ANTERIOR POLIOMYELITIS.....	<i>A. McCarthy</i> 793
LYLE CREELMAN WRITES.....	799
MEET YOUR EXECUTIVE COMMITTEE.....	802
IDEALISM AND THE FIRST-YEAR STUDENT NURSE.....	<i>Sr. M. Mooney</i> 807
THE STAFF STUDIES NUTRITION.....	<i>L. Miller</i> 810
SERVICE SOCIAL À L'HÔPITAL.....	<i>Soeur Ste-Fabienne</i> 815
WORK CONFERENCE REPORTS.....	818
DEMONSTRATION SCHOOL ADMINISTRATION COMMITTEE.....	<i>N. D. Fidler</i> 829
ANNUAL MEETING IN SASKATCHEWAN.....	<i>L. Wilson</i> 830
COOPERATION IN HEALTH SERVICES.....	<i>D. Mellish</i> 833
BOOK REVIEWS.....	842
NEWS NOTES.....	847
OFFICIAL DIRECTORY.....	856

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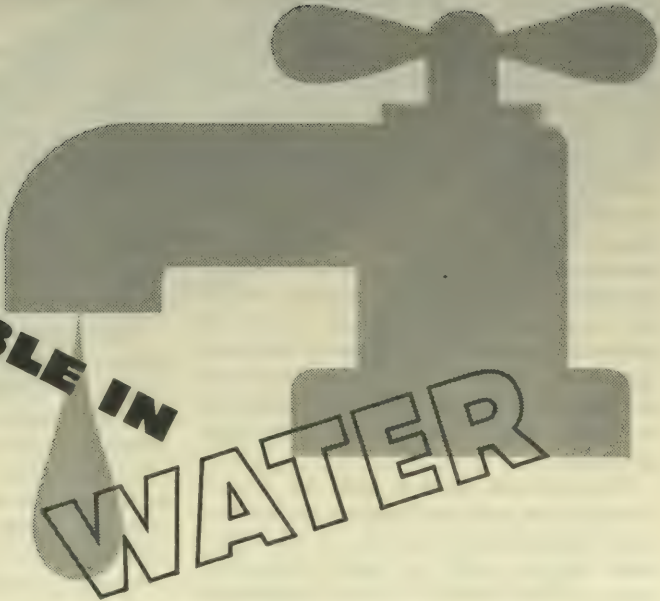
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1. Lewis, J. M., Bodansky, O., Birmingham, J., and Cohan, S. Q.: J. Pediat. 31:496 (Nov.) 1947.
2. Lewis, J. M.: J. Pediat. 6:362 (Mar.) 1935; *ibid.*, 8:308 (Mar.) 1936.
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Between Ourselves

The reports of the various **Work Conferences** are included in this issue. The dominant note that runs through most of them is the feeling that three half-days in the midst of a busy convention week is too short a period in which to do more than touch the fringe of the topics. Two or three reports suggest that such conferences be developed on the provincial and local level hereafter. It is an excellent proposal deserving very careful consideration by all the provincial groups. There are a sufficient number of nurses in every province now who are familiar with work conference technique to make such developments exceedingly profitable.

The suggestion has been made that if such programs are again included on the national level, several days, even up to one week, either before or after our regular convention period, be set aside for the work conferences. It will, of course, be up to the national Program Committee to make the decision as to the type of program. However, the members of that committee are always anxious to know what you, the nurses of Canada, really want. We suggest that you write your thoughts on this matter to our General Secretary, *Miss Gertrude M. Hall, Ste. 401, 1411 Crescent St., Montreal 25, Que.* Do it now while your impressions are still strong from this convention. What do you want? Write to your own provincial executive secretary expressing your opinion regarding such work conferences in conjunction with your own provincial convention. It takes time to get these programs organized so do not put off your writing until next year.

* * *

Brief mention was made last month regarding the **National Immunization Week** which is being celebrated this year **October 15-21**. Recently released figures giving the incidence and mortality data for diphtheria and whooping cough for 1949 indicate that

there is still a tremendous need for education in this phase of immunization. There were 79 deaths from 798 cases of diphtheria and 202 deaths from 7,942 cases of whooping cough. Somebody failed to give advice to parents, so 8,740 children in Canada had these preventable diseases! Somebody failed to urge immunization, so 281 children died unnecessarily! Don't be that "somebody."

* * *

You will find interesting information regarding the **food habits** of some of our racial groups in **Lorraine Miller's** article. She does not touch on the dietary differences of many of the nationalities that go to make up our cosmopolitan population. Who has some additional information that might be shared with our readers? We would be glad to receive this material—even fragments of it—that might be woven into another article.

* * *

Getting all set for your round of activities this winter? Clubs, nurses' meetings, work—what are you planning for yourself in the line of **hobbies**? Would you be interested in a series of articles describing various hobbies? Maybe you would get some ideas you would like to put into practice.

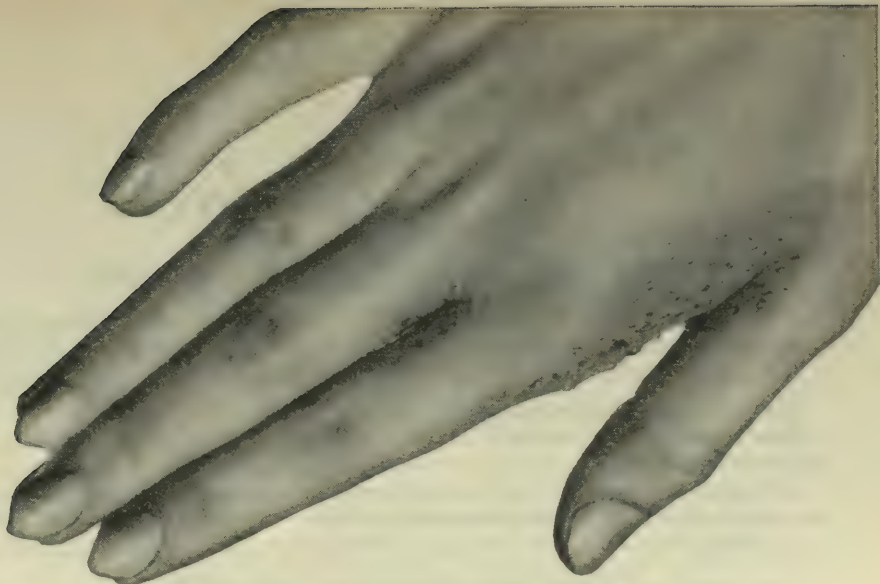
It is our conclusion that very few nurses have actual hobbies. If asked what are their favorite leisure-time activities, the great majority murmur rather vaguely about "reading and music." Serious reading material—the non-fiction books in a lending library—can supply a very real need in our lives for cultural information. Music, too, can mean a great deal or very little.

Why have hobbies? Each of us is living, working with a great many people every day—giving comfort, care, advice. What are we doing to replenish our own personalities? How are we re-creating ourselves? Shall we introduce a section on hobbies? It is up to you. Please let us know your interest in this matter.

Copies Available

Is there a school of nursing in the United States that would like to secure some back issues of *The Canadian Nurse* for their library? The librarian of the *Georgetown University School of Nursing, Washington 7, D.C.*, has

the following numbers available to the first comer who is willing to pay shipping costs: 1946—Apr. to Dec.; 1947 and 1948—complete. Write directly to M. Fromuth, librarian, at the above address.



on the one hand

an almost limitless variety of agents may cause pruritic dermatoses, presenting an imperative need for relief from itching.

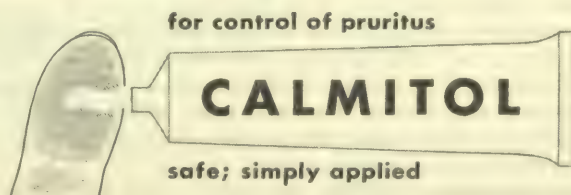
on the other hand

the antipruritic employed should not contain potentially dangerous drugs, lest the lesion be exacerbated. Phenol (as in calamine with phenol), cocaine and cocaine derivatives are among the hazardous stimulating and keratolytic agents warned against in the literature:

1. Underwood, G. B., and Gaul, L. E.: J.A.M.A. 138:570, 1948. 2. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. 130:249, 1946. 3. Howell, J. B.: Arch. Dermat. and Syph. 53:256, 1946. 4. Gaul, L. E.: Hygeia 23:280, 1945. 5. Gaul, L. E.: J.A.M.A. 127:439, 1945. 6. Lane, C. G.: J. Omaha Mid-West Clin. Soc. 6:45, 1945. 7. Miller, H. E.; Ayres, S., Jr., and Alderson, H. E.: California & West. Medicine 51:251, 1939. 8. Ormsby, O. S.: Diseases of the Skin, Philadelphia, Lea & Febiger, 1937. 9. Homans, J.: A Textbook of Surgery, Springfield, Charles C. Thomas, 1932.

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Description—Scored tablets of 25 mg. and 50 mg. of 4-acetylaminobenzaldehyde-thiosemicarbazone.

Indications—For trial in the treatment of pulmonary tuberculosis, alone or in conjunction with streptomycin or para-aminosalicylic acid.

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Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each cc. contains 100 mg. pyridoxine hydrochloride in water for injection, U.S.P.

Indications—The exact role of pyridoxine (vitamin B₆) in human nutrition is not known. For use as an adjunct in the treatment of multiple vitamin B complex deficiencies and of possible value in vomiting of pregnancy, chorea, paralysis agitans, and some muscular dystrophies.

BISTERONE SUSPENSION

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Each cc. contains, in aqueous suspension:

Orchisterone (Testosterone, Frosst) 50 mg. Pregnenolone 50 mg.

Indications—Chronic rheumatoid arthritis.

Cautions: Administered to normally menstruating women may cause delay, irregularity, or cessation of menses; signs of virilism such as acne, hirsutism, and changes in voice may follow long-continued treatment. Manifestations are reversible when treatment is stopped. No untoward effects in the male.

VIOFORM Cream, Ointment

Manufacturer—Ciba Company Limited, Montreal.

Description—Vioform is Ciba brand of 5-chloro-7-iodo-8-hydroxyquinoline. The cream contains 3% in a water-miscible base. The ointment contains 3% in a petrolatum base.

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Administration—Topically.

ESKELL

Manufacturer—Smith, Kline & French, Inter-American Corporation; Canadian distributors: Leeming Miles Co. Ltd., Montreal.

Description—A mixture of active principles, chiefly Khellin, from the plant, *Ammi visnaga*. Each tablet contains the equivalent of 40 mg. of crystalline Khellin.

Indications—For prophylaxis and treatment of angina pectoris and bronchial asthma. It is claimed that Khellin is a much more potent vasodilator than theophylline-ethylenediamine in the isolated heart; that it has a prolonged therapeutic effect with no demonstrable effect on blood pressure and pulse rate.

Administration—Initially, one tablet 3 times daily after meals (in a few cases 4 times daily) to produce "khellinization." Maintenance dosage should be determined in each individual patient. Anorexia, nausea, and dizziness are not infrequent but are not dangerous and can be controlled by careful regulation of dosage.

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3. Western J. Surg., Obst., & Gynec., 51: 150, 1943.
4. Med. Rec., 155: 316, 1942.
5. J. Health & Phys. Ed., 14: 154, 1943.

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MASSE NIPPLE CREAM

Manufacturer—Ortho Pharmaceutical Corporation (Canada) Limited.

Description—An absorptive, emollient, bacteriostatic and antiseptic cream containing 9-amino acridine 1:1000 and allantoin 2%.

Indications—For prophylactic nipple care during the antepartum and nursing periods and for the treatment of cracked nipples.

VOLUGEL

Manufacturer—E. B. Shuttleworth Chemical Co. Ltd., Toronto.

Description—A mixture of methylcellulose and carboxymethylcellulose, non-toxic, non-irritating, non-absorbable gels. Volugel tablets contain 0.5 gm. of mixture. Volugel stronger tablets contain 0.5 gm. of the mixture plus 0.7 mg. of the synthetic purgative, diacetylphenolisatin.

Indications—Conditions where a cathartic of the bulk-producing, colloidal type is indicated.

Administration—4 to 16 tablets daily until regularity is established. Then dose reduced gradually until none is required. Tablets should be washed down with plenty of water.

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Manufacturer—The Upjohn Company, Toronto.

Description—A sterile, biologically standardized solution of the steroid hormones of the adrenal cortex in cottonseed oil. Each cc. contains 40 rat. units (Survival-Growth) and is standardized by the Liver-Glycogen Deposition Test to be equivalent in biological activity to 1 mg. 17-hydroxy-corticosterone. Chlorbutanol 5 mg. per cc. To be stored in refrigerator.

Indications—Adreno-cortical insufficiency, as Addison's Disease and in surgical removal of the adrenal cortex.

Administration—Intramuscularly, in widely varying doses according to individual patient and condition. For maintenance in Addison's Disease, daily injections of 1 to 2 cc. are usually used.

NETHAPRIN CAPSULES

Manufacturer—Wm. S. Merrell Co., Toronto.

Description—Each capsule contains: Nethamine (methylethylaminophenylpropanol, Merrell) Hydrochloride 25 mg., Butaphyllamine (theophylline aminoisobutanol, Merrell) 60 mg., Decapryn (doxylamine, Merrell) Succinate 6 mg.

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Description—Each cc. represents Ascorbic Acid U.S.P. 1,000 mg. (20,000 units) as the methylglucamine salt of ascorbic acid.

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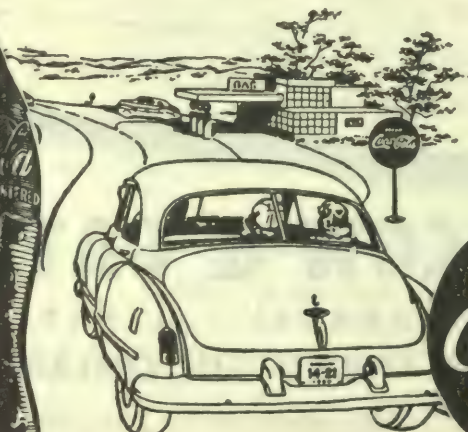
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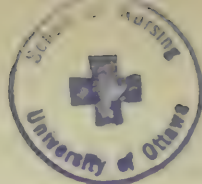
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The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX

NUMBER TEN

MONTREAL, OCTOBER, 1950

Pride Tempered by Humility

Average reading time — 6 min. 24 sec.

IT CAN ONLY be expected that Canadian nurses will look back at their recent biennial meeting with a great deal of pride. The summary in the August *Canadian Nurse* provides exciting reading to those who attended as well as those who stayed home to assure that nursing services for the people of Canada would be maintained while their confrères were away planning for the future. The very fact that we have grown to the point where 1,300 nurses could sit down together, at one time and in one place, points to our development and symbolizes our strength.

Have you ever thought what it would be like to have someone say to *you*—"In the name of the Association, I leave the affairs of all of us in your capable hands"? When "all of us" means over 30,000 nurses, at a time when the demands on this group continue to grow and may well become, in the words of the past president, Miss Cryderman, a National Emergency? A sobering and apprehensive thought, is it not? The apprehension could very quickly lead to destruction if it were not for the fact that looking into the past is comfort-

ing. Past presidents have guided the association ahead steadily and soundly. It is at a biennial meeting that nurses grasp the overall picture of what has been gradually developing through the years. The great variety of interests among nurses has contributed to this growth. Whether as president of the Canadian Nurses' Association, as a member of the Executive, or through provincial or branch representation; whether the interest of the nurse is in institutional, public health, or private nursing; whether her problem is in nursing education, labor relations, public relations, or the welfare of nurses less fortunate than ourselves, Canadian nurses have worked together step by step until, at this meeting, they attained a unity of purpose, an agreement for action that cannot help but be an inspiration for each of us in the future. I know it paid in some measure for the struggles, the frustrations, and the disappointments that frequently have faced our past presidents. There were several of them at the meeting. They could not help but see the importance of the threads that they and their executives

had contributed to the fabric of our association's life.

What was the most significant decision coming from this unity of thought and action? Of course there will be disagreement about this. Viewed in the light of the future development of the C.N.A., there is no doubt about the importance of the clear conviction that what we have accomplished is good but not good enough; that it is time to make an appraisal of our activities and achievements with a view to the improvement of services rendered. This decision, which for the present is being called the "Structure Study," demonstrates that we are ready to look at ourselves critically, to ensure, in the face of rapidly changing conditions, that what we have and do is sound and, if not, to find out how we may better serve the public. With that decision and the assurance that we at last are able to finance this and certain other of our immediate needs, we can turn to others outside our own professional group for understanding and active support.

What does this decision mean to the individual members of the Canadian Nurses' Association? At the next biennial your national Executive is expected to present a report that will have far-reaching implications for the nursing profession in Canada. That is the responsibility of those whom you have elected to office nationally and, as the C.N.A. is a federation of the provincial associations, it is the responsibility of the provincial executives as well. The need for self-appraisal is immediate. We cannot wait for two years to ensure that Canadian nurses take their rightful place in plans for the provision of health care for the people of Canada. The decision was made for the association and it behooves every nurse to enlarge her knowledge of nursing and nursing matters, to appraise her place within her community and her association at all its levels.

If we all accept this responsibility then the job is half done. The report, when it is received two years hence, will be partly accomplished and, following the biennial meeting in 1952, the new Executive will be able to implement the recommendations with the minimum clashing of gears and the maximum proficiency of performance.

If 30,000 Canadian nurses make up their minds to see that nursing fulfils its every possibility, then it will be done. We can already see the results when some of the nurses go to work seriously on a problem. We usually think of social change in terms of a hundred years. Yet, before our demonstration of an independent hospital school of nursing is much more than half completed, it has been announced that another such school is to be established in Canada immediately, based on the same idea but financed by four partners—a charitable foundation, the provincial department of health, the federal Department of Health and Welfare, and the hospital itself. Progress can be made quickly.

With such a review of the past, to be president of the Canadian Nurses' Association is a matter of great pride. Looking toward the future with the tools at hand provided by those who fought to bring us to maturity, apprehension becomes humility. Your new Executive is, in a large measure, untried in the national field, but they know they have the support of Canadian nurses who have had the experience of bringing this association through difficult years. We have the hope that many nurses will take a new or renewed interest in nursing affairs. Then all of us, with pride tempered by humility, will meet the demands of the future no matter what they may be.

HELEN G. McARTHUR

President

Canadian Nurses' Association

Whether you be man or woman you will never do anything in this world without courage. It is the greatest quality of the mind next to honor.—JAMES L. ALLEN.

Recovery Room

HAROLD R. GRIFFITH, M. D.

Average reading time — 5 min. 36 sec.

THE IMMEDIATE post-operative period is a time when surgical patients should receive continuous skilful nursing care. For some patients the kind of attention received during this critical period may tip the balance between death or recovery. In order to be sure that all the advantages of modern specialized knowledge and equipment would be available for such patients, in 1943 we organized a Post-Operative Recovery Room at the Homoeopathic Hospital of Montreal. Since that time nearly 15,000 patients have passed through this department and we can say without hesitation that this is one of the best investments ever made. The advantages of a recovery room from the point of view of nursing efficiency and economy are fully and fairly covered in Miss Honey's excellent article which was published in the June, 1950, issue. I need only say that we agree entirely with her observations and that equally valuable advantages are apparent to anesthetists, surgeons, and to the patients themselves.

To set up a recovery room in an already over-crowded hospital may seem impossible. However, once we decided such a department was necessary, we gave it first priority, improvised space in what had been a partly enclosed solarium, and "sold" the idea to our Women's Auxiliary who raised the money needed for special equipment. The shape of our room is not ideal. It is too small for comfort but it has accomplished its purpose. A makeshift arrangement of some kind is possible in almost every hospital, because "where there's a will there's a way." It is wrong to feel that one must always wait for a new building or a new wing to pro-

vide such a valuable and satisfying addition.

The following are some practical points which, in the light of seven years' experience, we believe to be of importance to anyone who may be contemplating starting a recovery room in either an old or a new hospital. We realize that special circumstances may necessitate the modification of some of these suggestions.

DIRECTION

Medical direction of the recovery room is best undertaken by the anesthesia department. The modern anesthetist is well qualified to look after restorative procedures, oxygen therapy, blood transfusions, parenteral fluid service, and the handling of unconscious patients. With us, there has been no conflict between the authority of anesthetist and surgeon. For as long as the patient must remain in the recovery room the anesthetist assumes responsibility and the surgeon acts in a consulting capacity. Since there is confidence in the anesthesia staff, the surgeons are glad to be free of this responsibility and they know that their patients are receiving the benefit of the best in medical knowledge and nursing skill.

NURSING STAFF

Just as important as good medical direction is the proper selection and training of the nursing staff for a recovery room. An alert, intelligent graduate nurse should be selected and specially trained, then given this department as her full-time job. Since the work is interesting, stimulating, and satisfying, there should be no difficulty in finding suitable nurses. We have been singularly fortunate in this regard and the only reason we have had to change our recovery room nurses is because they seem to be prone to the infection of matrimony.

Genial Dr. Griffith is medical superintendent and anesthetist-in-chief of the Homoeopathic Hospital, Montreal.

The number of nurses required will depend on the amount of surgery being done. In our small hospital, with an average of seven operations a day, we have always on duty one graduate and one student nurse. For a hospital with a school of nursing it is most important that students get an opportunity for this specialized and highly valuable training.

SIZE AND LOCATION

An adequate recovery room should have space for as many patients as there are active operating rooms. In our hospital patients are brought from the O. R. on their own beds. This is an ideal arrangement since it obviates the extra dangers of frequent changes of position for anesthetized patients but we realize it is not possible in every hospital. We bring practically all post-operative patients to the recovery room—not only those who are in serious condition. For a patient with spinal anesthesia it is just as important to have constant attention until the anesthetic has worn off as it is for the patient recovering from ether or cyclopropane. Children are brought there after tonsillectomy so that they can get their often noisy awakening over in seclusion and so not upset their mothers or other patients in a ward. It is not necessary to have separate rooms for male and female patients—a curtain that may be pulled across between beds provides sufficient privacy.

It is important that the recovery room should be adjacent to or in proximity with the operating room. This permits closer liaison between anesthetists and recovery room nursing staff and minimizes transportation difficulties.

DURATION OF PATIENT'S STAY

Whether the recovery room is organized for day-time only or for 24-hour service will depend on the number of cases to be handled, the nature of the operations, and the space available. In our recovery room the patients stay only until they are awake and do not need constant nursing attention. However, if we were

planning a new hospital, I would recommend an arrangement whereby patients could be cared for as long as two or three days in the recovery room so that the occasional complications which arise in cardiac, thoracic, and abdominal cases might be handled expeditiously and efficiently. The average patient would still be out of the recovery room in an hour or two but, if it were possible to keep complicated cases there much longer, there should be less difficulty in maintaining routine nursing care for the less demanding patients in the surgical wards. This is in line with the modern idea of "graded nursing care."

FINANCING THE RECOVERY ROOM

We have made no charge to the patient for recovery room nursing care, although the usual service charges for blood transfusions, intravenous therapy, and other drug administrations are made. For purposes of convenience, we have combined our Blood Bank with the recovery room, under the same medical and nursing supervision. This arrangement might not be suitable for another hospital. With us, it has run so smoothly that we have not yet joined the Red Cross Blood Transfusion Service. The service charges from 800 blood transfusions given annually have covered the whole cost of the recovery room. However, even if this source of revenue was not available, we would still recommend the installation of a recovery room as a good investment.

OTHER USES

A hospital department which is set up with readily available equipment for all kinds of supportive treatment may well be used for other than post-operative patients. Any patient who needs to be intubated for respiratory obstruction, or to have tracheal aspiration performed for atelectasis or increased secretions, may be handled most expeditiously in the recovery room. It is used for poisoning cases and for comatose patients who are being investigated.

Acute Anterior Poliomyelitis

ANNABEL MCCARTHY

Average reading time — 20 min. 48 sec.

ONCE AGAIN the savage hand of poliomyelitis, or infantile paralysis as it was formerly classified, has dealt its brutal blow on the province of Ontario. The toll of the epidemic in 1949 was the heaviest experienced since the epidemic in 1937 in which there were some 2,544 cases reported with 116 deaths or 3 per 100,000 population.

The accompanying Tables I and II illustrate the prevalence of the condition, its devastation to life, and the fact that it tends to run in cycles. These figures include only those cases which have been serious enough to warrant hospitalization but it is felt that there have been almost as many more unrecognized or undiagnosed cases which may have played an important role as carriers.

Epidemiologists have expressed the opinion that the ratio of clinically recognized cases to non-symptomatically infected persons was somewhere between 1-10 to 1-100.

INCIDENCE

The occurrence of this disease is world-wide with sporadic cases appearing around the globe. Epidemic prevalence is more marked in temperate latitudes. There is no racial immunity nor does it appear to be influenced by social or economic status. No longer is it a disease of infants as was formerly understood. All age groups are affected—those reported in Ontario ranging from 4 months to 64 years. The case rate is higher among males, particularly in the older age group. In Ontario the

TABLE I
ACUTE ANTERIOR POLIOMYELITIS IN ONTARIO

Year	No. of Cases	No. of Deaths	Paralytic	Non-Paralytic
1937	2,544	116		
1938	160	18		
1939	216	13		
1940	87	12		
1941	140	12		
1942	89	9		
1943	81	7	51	30
1944	332	21	157	175
1945	183	11	83	100
1946	512	33	235	277
1947	792	31	366	442
1948	369	21	125	244
1949	1,135	69	404	731

Miss McCarthy, a medical supervisor at Toronto Western Hospital, was herself a polio victim in 1949. She prepared this material in the hope that it would be helpful to other nurses who have had little to do with the disease.

disease is most prevalent during the warm dry months—from May to November. In contrast to this, a serious epidemic occurred among the Eskimos in the eastern Arctic region of Canada during the months of February and March, 1949.

TABLE II
CASES TREATED IN RIVERDALE ISOLATION HOSPITAL, TORONTO

<i>Year</i>	<i>Total No. Cases</i>	<i>Deaths</i>	<i>Died in Respirator</i>	<i>Cases Requiring Respirator</i>
1937	501	23	2	15
1942	9	0	0	—
1943	15	3	—	—
1944	56	1	—	—
1945	34	2	2	2
1946	105	9	5	10
1947	190	7	5	11
1948	70	6	5	6
1949	260	24	6	15

ETIOLOGY

Anterior poliomyelitis is a virus infection. The virus multiplies only in the presence of nerve tissue with the greatest concentration of organisms found in the spinal cord, medulla, and mid-brain. It is not found in the blood or cerebrospinal fluid. There is no known living reservoir for the organism other than man, but it has been known to retain its vitality for 200 days in feces. It is stated that if the colon of the infected individual is not emptied by regular evacuation, during the early stages of the disease, the virus which accumulates in this area will tend to re-infect the patient, causing a second febrile period.

Nasal and pharyngeal secretions and feces have been found to be the chief sources of infection. The ways in which the organism may reach man are: droplet infection—direct, through personal contact; indirect, through such vehicles as towels, dishes, and dust; food, milk, and drinking water which have been contaminated by flies or fecal matter; water in rural districts, which is used for swimming or washing dishes.

Fatigue, pregnancy, trauma such as a tonsillectomy which leaves afferent nerve fibres exposed, all predispose to the development of the disease. Muscular effort in the pre-paralytic stage may have some bearing on the localization of paralysis.

At first, it was generally accepted that the organism entered the body and travelled along the nasopharyngeal neural pathways to reach the anterior horn cells, but it now seems probable that there are other potential pathways from various levels of the alimentary tract. It is believed that all muscle power and tendon-reflex loss are due to infection of the anterior horn cells with possible paralysis of the hundred or more muscle fibres supplied by each. Hence, recovery of the neuron function would only follow repair of cells which have not reached a stage of neuronophagia. The disease is characterized by the dissemination of involvement, following no set pattern or symmetry. An apparently normal muscle may have some paralyzed fibres. It is not uncommon to find a right leg and a left arm affected in one individual. Only one of the several muscles called into play in performing the function of a limb may present a marked weakness.

PRODROMAL SYMPTOMS

The incubation period of the disease ranges from 5 to 35 days, the majority of cases being from 5 to 14 days. When the virus has multiplied sufficiently to form toxins certain characteristic symptoms become evident. These include: fever headache, listlessness, nausea and vomiting, constipation, sore throat, stiffness of the neck and spine giving rise to inability to touch

the chin on the chest or bend down to touch the feet without experiencing pain; muscle tenderness and irritability.

ONSET

The symptoms may subside at this point and the case would be classified as non-paralytic or abortive. However, it may advance to the more serious phase—the paralytic type. The development of weakness may be spontaneous or gradual in its distribution but the extent of the paralysis is usually maximal within a few days of the onset of the symptoms. This does not hold in the case of a muscle which has become over-fatigued because permanent damage may be done for several months after onset if this occurs. Regeneration of the nerve fibres controlling these muscles varies in rapidity depending on the extent of the damage encountered. Maximal recovery usually is experienced within the first six months but may be prolonged at a slower rate up to two years.

Bladder involvement is quite common during the early stages, necessitating catheterization. This function returns eventually. Stasis of the bowel occurs in the majority of cases due to loss of power in the abdominal muscles. This requires prolonged and constant treatment with enemata. Harsh purgatives are avoided, thus preventing overwork of the weakened musculature of the intestinal tract. Cases where there is marked loss of tone may be given a Mayo enema which is very effective in producing peristalsis. This is made with 1 oz. soda bicarbonate, 2 oz. granulated sugar, 8 oz. water, and given at a temperature of 105°F. When power begins to return, regulation of bowel habits may be achieved quite effectively by the use of agarol and roughage in the diet.

FASTIGIUM

Death is commonest on the fourth day of the disease with 90 per cent of the deaths occurring in the first fortnight—almost always from acute respiratory failure. Apnea results from

either concurrent intercostal, diaphragmatic paralysis (spinal lesion) or from involvement of respiratory centre (bulbar lesion). Asphyxia may follow laryngeal spasm or paralysis or the pooling of mucus in the throat.

TREATMENT

The treatment of acute anterior poliomyelitis is carried out in three stages: (1) A period of rest, during which measures are carried out to prevent deformities; (2) physiotherapy; (3) the chronic stage with reconstructive surgery.

Rest is the keynote to recovery throughout the whole course of the disease but particularly during the acute stage while there is any inflammation present. This is one of the easiest things to order but most difficult to carry out and must be both general and local. All febrile cases must have complete bed rest. During this period, the patient should be kept in as nearly a normal posture as possible without causing distressing discomfort. Local rest is achieved by the use of splints or foot-boards as indicated. Muscle tenderness is an indication that the lesion in the spinal cord has not reached its finality. The patient must remain at rest as long as this is present. Any recurrence while under treatment means a return to the rest period. It is rather appalling for the bread-winner of a family or the mother of a small child. It requires a great deal of tactful explanation and reassurance on the part of the attendants. What is six months now compared to the rest of a lifetime?

PHYSIOTHERAPY

When all the inflammation has subsided, the all-important work of the physiotherapist begins. It is on this phase of the treatment that we rely for the increase in the power of the affected muscles. The first approach is in muscle re-education and isolation of movement. This must be done by a person with a good working knowledge of anatomy who can be sure they are training the right muscles. The patient in his enthusiasm

to produce movement will tend to build up an already strong muscle, which may be either antagonistic in its function or carry the movement in an abnormal direction, resulting in future deformity. To relieve muscle spasm and increase range of movement the use of moist heat is helpful. It is generally felt now that the Kenny method of treatment is a little outdated. It was not a cure and took considerable staff to change the packs which cooled quickly. It did, however, have a sedative effect on the patient, cutting down on the need for analgesics. It also had a psychological effect on both the patient and the relatives in so far as they felt that there was action and plenty of it. Even more important, it did stimulate the medical profession to renewed effort in the hope of finding some means to reduce the high percentage of cripples.

Supervised exercise in a warm pool has proven very helpful. The heat is relaxing, allowing an increase in the range of movement. Moreover, the buoyancy of the water aids the patient in his endeavor to improve the normal function of the limb by relieving much of the weight.

Muscle power is evaluated and recorded at various stages of the disease. In the past, this was done by the estimation of the examiner in a subjective analysis of potential muscle power and graded as normal, fair, or nil. The Ontario Government has now installed a machine known as an "electromyograph" at the polio research centre at Thistletown. The purpose of this machine is to make a scientific grading as a percentage of normal of the power of the muscle during contraction. It is hoped that with this machine it will be possible to determine the approximate time of recovery, the relationship between pain and muscle spasm, and evaluate certain drugs as to their ability to relieve pain and spasm.

AMBULATION

When the patient becomes ambulatory, great care must be taken to avoid over-fatigue. A normal muscle

when overworked will tire and lose power. This occurs much sooner in polio and, if not recognized, the damage may be permanent. The appearance of fatigue is evidenced by a regression of power and a lessening of range of movement.

Orthopedic braces, splints, belts, and correctives have played a valuable role in aiding people to fulfil a useful place in life. These should be light and a good fit. The new paraplegic chairs are easily manipulated and allow patients with lower limb involvement to get out of bed at a much earlier date. These individuals, however, should not be allowed to become too dependent on this means of locomotion and give up the fight for their own power.

Life has been maintained in many patients with marked respiratory embarrassment by the use of the respirator. In these cases the lesion is high and there is usually involvement of the arms, legs, and trunk. Here again reassurance and explanation are most essential, particularly when removing the patient from this machine which has been breathing for him. There is a great fear of having their "wind cut off" and in many of these individuals sleep cannot be induced even with the use of strong sedatives. There are new respirators on the market which cover the chest alone. This leaves the rest of the body easily accessible for nursing care and physiotherapy treatment. Some of the cases with respiratory distress may be relieved by placing them on a rocking bed. The rhythmic drop and elevation of the foot of the bed causes the diaphragm to fall and rise, thus allowing the chest cavity to fill and be emptied of air. The shorter period these devices are required the better is the prognosis, although life has been maintained in this manner for several years.

When no further change is to take place, or the so-called chronic stage has been reached, then and only then should reconstructive surgery be resorted to. This includes operations on tendons, fascia and ligaments, or bone surgery by the hands of a surgeon skilled in that line of work.

There is no specific drug, sera, or antibiotic which has proven helpful either in the prophylaxis or cure of poliomyelitis. It is felt that infants acquire an immunity for the first few months of life from the mother. Second attacks are uncommon and, if such occur, are thought to be due to invasion of a different strain of the virus than that causing the primary attack.

In making a diagnosis of anterior poliomyelitis, certain findings are expected:

1. The presence of virus in material prepared from: (a) throat swab taken during the first week; (b) feces up to three months.
2. Typical histological lesion in the central nervous system after death.
3. Typical changes in cerebrospinal fluid: (a) Rise in total protein above 45 mg. per 100 ml.; (b) positive globulin (Pandy's test)—50% of cases; (c) raised total cell count—above 1 per 3 cu. mm; (d) predominance of mononuclear cells; (e) absence of bacteria, spirochetes, fungi, or protozoa; (f) negative Wassermann.

NURSING CARE

To provide good nursing care in this disease is a challenge to any nurse. It requires skill, tact, understanding of the disease and of people, sympathy, a cheerful bedside manner, a desire to help, and the ability to teach and to gain confidence. The nurse is dealing with an individual who has undergone a general upset of the whole nervous system and there is a large psychological element to be dealt with as well as the physical defects encountered. She is one of the chief crutches on which the patient leans when he awakens to the fact that he is ill, that he has lost the use of a limb or perhaps his entire body, and has no reassurance as to when, if ever, he will regain this power. Explanation, efficiency in work, and an optimistic outlook on the part of the nurse do a great deal to put the patient at ease both physically and mentally.

During the acute phase of the condition, it is the nurse's duty to institute appropriate measures. Pillows

may be used to position a limb, taking the strain off it. These should be placed under the direction of the physiotherapist because here again a pillow placed incorrectly may cause undue tension on another muscle and in this way do damage. A limb which is lying helpless should be guided with a firm steady movement in changing position, giving support to the whole limb. It can cause great pain to carry the weight of a limb by means of a tight grasp on the body of a muscle.

Bedding should be warm but light. There is an impairment of circulation in the lower extremities which tends to cause muscle pain, aggravated by chilling. A hot-water bottle frequently relieves this but great care must be taken not to burn the patient, particularly when sensation is poor or the patient is unable to move away from the heat. Heavy blankets tend to tire a patient and can readily cause foot-drop. These people perspire freely during the acute phase and on exertion while weakness is present, necessitating a frequent change of bedding to avoid chilling. Good care to the skin with frequent bathing is most essential, not only because some of these patients are bed-ridden for many months but also because there is a characteristic heavy body odor which accompanies the disease and may be very embarrassing.

Because of the degeneration which takes place in the affected tissues, it is very important that good nutrition be maintained. Here again the nurse plays an important role in supervision and in assisting the patients to eat a nutritive and attractive diet. The majority of the bulbar cases require gavage feedings. It is the nurse's duty to see that these are given on time and that the tube is washed out routinely to prevent milk products from souring in it.

Keen observation and the ability to interpret symptoms are essential in providing intelligent care for these people. It is the nurse who is in the optimum position to notice a distended bladder, with inability to void, the onset of respiratory difficulty,

drowsiness, or unusual headache ushering in an encephalitis, deformity from poor posture, or extension of weakness or paralysis. Anticipating the needs of the patient before they have become concerned about them—a sip of water, a limb that requires turning, hair that needs brushing—all aid in the general comfort of the patient.

Convalescence is slow and much needs to be done to prevent the patient from becoming discouraged. Occupational therapy, recreational activities, such as reading, motion pictures, needlework or leatherwork, help to occupy the time and show the patient that he will still be able to take a place in life, regardless of his disabilities. As soon as they are able, these patients should be encouraged to do little things for themselves and not continue to be dependent.

CONTROL

Although there is still much more to learn about the disease there is much that can be done to aid in its control. Governmental authorities, realizing the seriousness of the situation, have made provision for hospitalization for all infected individuals. It is a disease reportable to the Department of Health and public health officials carry out an extensive

search in an endeavor to locate the source of infection and follow up contacts. Early diagnosis is important as well as hospitalization, with adequate nursing care. Isolation should be continued for three weeks with concurrent and terminal disinfection, paying particular attention to proper handling and disposal of discharges from the nasopharynx and fecal material. Education of the public and adequate after-care to prevent crippling should aid in the attempt to cut down on the devastation wrought by this dread disease.

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Terramycin in Pneumonia

Of 25 patients with severe cases of pneumonia, 100 per cent were cured when treated with terramycin, according to reports by a group of four doctors at the Columbia-Presbyterian Hospital in New York. The results of this therapy with terramycin, newest discovery among the earth-mould drugs, are detailed in the current issue of the *Journal of the American Medical Association*.

Eighteen of the cases were bacterial lobar pneumonia and seven were virus (primary atypical) pneumonia. The results indicated, according to the doctors, that "terramycin is remarkably effective in the treatment of both types of infection."

There were no complications and all

patients made a rapid and complete recovery. Among the patients with lobar pneumonia, with the exception of one subject, the doctors said there was "a dramatic fall in the temperature within 24 to 36 hours after the first dose of terramycin was given." Temperatures of the virus-pneumonia patients fell within 36 hours after the first dose of terramycin.

The doctors found no serious toxic effects attributable to the terramycin therapy and in only 9 of the 25 cases did any symptoms of gastrointestinal irritation occur. "These resembled the symptoms seen after the administration of aureomycin," the doctor reported, "but seemed less severe." In all cases, terramycin was administered by mouth

Lyle Creelman *Writes . . .*

Average reading time — 6 min. 48 sec.

THE PATTERNED farmlands bordering the Danish coastline are slipping past below. I am on my way to Amsterdam from Göteborg, Sweden, where I have been attending the Quadrennial Congress of the Northern Nurses' Association, which was held July 2-6.

Göteborg, known as the "Gateway to Sweden," is a city of beautiful fountains, parks, and water-ways. It was founded in 1621 and today ships from far distant parts of the world drop anchor in its harbor. It is also the home port of the Swedish-American luxury liners.

The Congress was held in the Mässhallen outside of which were flying the flags of all the countries represented at the Congress. Someone expressed their regrets that it had been impossible to find a Canadian flag but as I was representing WHO it was quite right that a Canadian flag was not included. Before the Congress was over, however, I did step out of my official role and, as a Canadian, extended greetings from all of you at home.

The 1,250 nurses in attendance

came from the five countries of Northern Europe—Sweden, Norway, Denmark, Finland, and Iceland. Included also from each were representative student nurses. Some came in their national costumes, adding a note of color to the meetings and the festive occasions. The opening of the Congress was attended by the Crown Princess Louise of Sweden and I had the added honor of sitting beside the Princess at the opening session. She is a charming and gracious person, keenly interested in nursing activities. Dr. Axel Höjer, who is a general director of the Department of Health in Sweden and also a member of the Executive Board of the World Health Organization, gave the first address, speaking on the program and policy of WHO.

The International Council of Nurses was represented by Miss Daisy Bridges, executive secretary, who also spoke at the opening session and brought greetings from the nurses of other countries in the world. Two visitors from the United States brought personal greetings from American nurses.



Opening session of the Quadrennial Congress of the Northern Nurses Association. Miss Creelman, the Crown Princess, and the vice-president of local nurses' association are in foreground.



Norwegian nurse in national costume.

The principal theme at the Congress was the integration of public health, not only into the basic curriculum for nurses but into post-graduate courses as well. On the first day, four very interesting papers were presented on this subject, starting with the integration into the basic curriculum of a school already established; then, how you would integrate public health when you were planning a new school; thirdly, methods of integrating public health into the program of staff education in a hospital; and, lastly, the subjects which should be included in post-graduate courses for fields other than public health nursing. Of course, I really did not understand one word that was being said but from the vivacious manner of presentation by the speakers, the interest of the audience, and the highlights which I heard interpreted later, I know that the Northern nurses are well advanced in their thinking along these lines. The day following the presentation of this main theme, small groups were organized to discuss details and on the last day of the Congress reports were presented with appropriate resolutions.

Another special topic discussed was the responsibility of national nursing associations to act as "bargaining agents" and the relationship

of national associations with trade unions. We gathered that the nurses of these countries are very strongly in favor of strengthening their professional organizations but, at the same time, they believe that they should belong to the same associations as the other personnel with whom they work daily in their respective agencies or institutions. Another session of the Congress was conducted as a panel discussion on the nomenclature and duties for all groups of nurses. Are not these just the same topics which are being discussed the world over in professional nursing groups?

Highlights of the Congress were visits to small country towns about three hours outside Göteborg. The group of which I was a member visited the little fishing town of Lysekil (not pronounced at all as it is spelt!). Here we were met by the city officials and, after a lunch served in true Swedish hospitality, we boarded a boat and had a delightful two-hour cruise among the islands of the Swedish coast. It reminded me very much of parts of Nova Scotia's rocky coast-line. After returning, we were the guests at the beautifully equipped and modern country hospital and, here again, were served a wonderful meal. Feeling tired, but very relaxed and delighted to have met new friends, we were waved on to the train for our return to Göteborg.

The Congress closed with a reception and garden party in the spacious grounds of a tuberculosis sanatorium on the outskirts of Göteborg. Here all 1,250 of us were served supper, following which we sat on a sloping hillside in the long northern twilight and watched enacted some of the scenes from the Chronicle play which so many of you saw in Stockholm last year. During the supper hour a plane flying over dropped hundreds of bouquets of flowers—greetings from the doctors to the Congress members and their guests!

I remained in Göteborg one day following the Congress, so that I could visit some of the public health

nurses and learn something of their work in Sweden. There, a generalized public health nursing service, which includes bedside nursing, is being developed. This, however, does not include prenatal care and maternity care which is given by the district midwives. As an increasingly larger percentage of mothers are being delivered in hospitals, the future of district midwifery is under discussion. I visited a small child health centre where the mothers bring their babies and receive very kindly and efficient teaching from the public health nurses and the doctor. One hundred and twelve newborn babies had been admitted to this centre since January 1 and all but one had had BCG immunization before leaving the hospital. This one baby was of non-Swedish parents! BCG vaccination

is voluntary in Sweden but practically all parents desire it for their children. I visited also a new district health centre, a beautifully constructed building, containing consultation rooms, examining rooms, and dental rooms. It was one of the type being planned for many districts in Sweden. I regret to say that I did not see any like it when I travelled across Canada!

I am sure that now the land below is the Netherlands and that very soon we shall be landing at the Schipol Airport near Amsterdam. From there, I am going on to The Hague where, with Helen Martikainen, chief of our Health Education of the Public Section, plans will be initiated for a working conference for public health nurses, which will have participants from ten European countries. I shall be telling you about it later.

In the Good Old Days

(The Canadian Nurse, October 1910)

"Florence Nightingale was born in 1820, her father being a Mr. Shore who, on inheriting estates in Yorkshire and elsewhere, had taken the name of Nightingale. Her maternal grandfather was one of the many philanthropists who between them helped to bring about a cessation of the slave trade. . . .

"Miss Nightingale did not return home from Scutari until the very last of the hospitals had been closed. A man-o'-war had been told off to convey her home as a mark of the Government's share in the enthusiasm created by the work of herself and her assistants, but quite characteristically she came home alone in a foreign ship under an assumed name."

* * *

"Nursing is now a definite occupation, competing for recruits almost on the same footing as other occupations for women. It is attracting a much smaller proportion of ladies than was the case some years ago, and heads of some great institutions are reported to be finding a difficulty in securing probationers of the kind they would desire. In the hospitals the nursing is perfect from a technical point of view, but there is also in most of them some lack of the kind of spirit com-

monly associated with the name of nurse."

* * *

"The Victorian Order of Nurses of Hamilton is doing a splendid work through its Clean Milk Committee. This committee has issued a pamphlet entitled 'How to Take Care of Babies during Hot Weather,' which contains many helpful hints and much sound advice. The far-reaching benefits of this work cannot be estimated and the V.O.N. is to be commended for the inauguration of this work on behalf of the little children."

* * *

"During labor, the nurse can help her patient by massaging both sides of the spine—this is claimed by some to give almost painless delivery."

* * *

"Registration is one of the very important matters we have to deal with in the future. The preparation is being handled in such a way that all graduates of good standing should be proud and eager to offer their support. Registration is a necessity and when we are called upon to assist in establishing this we must firmly stand our ground and push forward to claim our rights which have been withheld from us so long."

Meet Your Executive Committee

Only a small proportion of the nurses of Canada were present at the C.N.A. convention in Vancouver when the new officers, chairmen of national committees, and members of the nursing sisterhoods were installed in office as the Executive Committee of the Canadian Nurses' Association. The new president, **Helen McArthur**, was introduced through the pages of our August issue. We take pleasure in presenting to our readers the other members of the Executive who will guide the affairs of our association for the biennium of 1950-51.



HELEN MCARTHUR

Ethel M. Cryderman, immediate past president, is as widely known as the capable superintendent of the Toronto branch of the Victorian Order of Nurses as for the energetic leadership she demonstrated during her term in office as president. Internationally, Miss Cryderman headed the Canadian delegation to the 1949 I.C.N. Conference in Stockholm. She spoke forcefully for Canadian nurses at the several meetings of the Board of Directors of the I.C.N. At home, she gave constant and careful consideration to the professional problems confronting us and rallied strong leaders to her side in steering a successful course. Her knowledge of nursing affairs will make her a valuable counsellor to the new president and the Executive Committee.

Seldom has there been such a complete change in the ranks of the vice-presidents of our association. Coming to the fore as



ETHEL CRYDERMAN

first vice-president is **Gladys J. Sharpe**, director of nursing at Toronto Western Hospital. This will be Miss Sharpe's first term of office on the national Executive though for four years she was convenor of the national Committee on Instruction. She has been a vice-president of the Registered Nurses' Association of Ontario for the past year.

Miss Sharpe has had a distinguished career in nursing. Following graduation in 1925 from Toronto Western Hospital, her service on the staff there was interrupted by a year's work at the McGill School for Graduate Nurses in 1927 and by her selection as recipient of the Florence Nightingale International Foundation Scholarship awarded in 1935 for study at Bedford College, University of London. During World War II, Miss Sharpe acted as liaison officer between the Canadian



John Palmer, Toronto

GLADYS J. SHARPE

nurses who enlisted for service in South Africa and the government. The distinguished service she rendered earned her the Royal Red Cross. After completing work for her B.S. degree from Teachers College in 1946, Miss Sharpe was appointed the first director of the course in nursing education at McMaster University, Hamilton. She returned to Toronto Western to assume her present duties in 1949. Thoughtful, far-sighted, and well informed, Miss Sharpe will give strong leadership in her new role as first vice-president.

Trenna G. Hunter moves up from two years' experience as chairman of the national Committee on Public Health Nursing to the responsibilities inherent in the office of second vice-president. As the successful director of nursing service in the large organization that is responsible for public health nursing service in Vancouver, the Metropolitan Health Committee, Miss Hunter brings representation from the Pacific Coast to the Executive. A graduate of the Vancouver General Hospital and holding her B.A.Sc. (nursing) from the University of British Columbia, Miss Hunter's experience has given her a broad understanding of current nursing problems and an appreciation of the necessity for nurses themselves to take the initiative in solving these problems. Her analytical mind and ability to get things done will be a strength to the new Executive.



Alfred Knight

TRENNA HUNTER



Harold K. White, Winnipeg

BERTHA L. PULLEN

Bertha L. Pullen, the third vice-president, is making her first entry on the national nursing scene. A graduate of the University Hospital of Chicago in 1918, Miss Pullen had already had a very active professional career before she assumed her present duties as superintendent of nurses at the Winnipeg General Hospital. Immediately following graduation she sampled private nursing, general staff work, office nurse and head nurse duties. In 1922 she began her degree work at Teachers College. After receiving her B.S., Miss Pullen became educational director at Norwegian Hospital, Brooklyn. In 1927 she went as supervisor to the Anna Nery School of Nursing in Brazil, becoming superintendent of nurses there the following year. After three years, she became associate dean of the school of nursing at Baylor University, Dallas, Texas. In 1933 Miss Pullen returned to her former position in Brazil until she decided to resume her studies at Columbia. Receiving her M.A. in 1939, she became director of the school of nursing at Methodist Hospital, Indianapolis, where she remained for five years.

Miss Pullen has been active on, and in many cases chairman of, numerous professional committees in the United States, including Indiana State League of Nursing Education, Nursing Council for War Service, Red Cross Nursing Service Committee, etc. She has also found time for membership in the Women's University Club, Soroptimist Club, Business and Professional Women's Club, and the Canadian Institute of Inter-

national Affairs. With this exceedingly diversified background of interest and activity, Miss Pullen will make a valuable contribution to the thinking and action of our Executive.

NATIONAL COMMITTEE CHAIRMEN

Mary E. Macfarland, who is the new chairman of the Committee on Institutional Nursing, is very familiar with all of the activities of the modern hospital. Ever since her graduation from the Toronto General Hospital in 1926, she has displayed a capacity for leadership which was demonstrated in the increasingly responsible positions she has occupied on the staff of the Toronto General Hospital. In 1937 Miss Macfarland was awarded the Jean I. Gunn Scholarship and engaged in post-graduate study in teaching and supervision at the University of Toronto School of Nursing. She assumed her present responsibilities as superintendent of nurses at T.G.H. in 1942. In the tradition of her predecessors in this position, Miss Snively and Miss Gunn, she is keenly interested in the cultural as well as the professional side of her nurses. She is a clear thinker, broad-minded, and alert to the importance of the work of the committee which she now chairs.



Randolph Macdonald, Toronto

MARY E. MACFARLAND

Helen M. Carpenter has been vitally interested in every phase of public health nursing since her graduation from Toronto General Hospital and the University of To-

ronto in 1933. As chairman of the Public Health Nursing Section of the Canadian Public Health Association, Miss Carpenter has been a member of the executive of the Committee on Public Health Nursing, C.N.A. This experience will be valuable to her in her new function as chairman of our national committee. It will also help to iron out possible instances of overlapping in the activities of these two important committees.

After eight years' work with the Victorian Order of Nurses in Hamilton and Toronto, Miss Carpenter received the award of a T.G.H. alumnae scholarship. She proceeded to Teachers College where she completed the work for her B.S. degree in 1943. At the end of one year as consultant in public health nursing with the B.C. Board of Health, Miss Carpenter was awarded a Rockefeller Fellowship. She secured her M.P.H. from Johns Hopkins University in 1945. She was appointed to the dual role of lecturer in public health nursing at the University of Toronto School of Nursing and supervisor of the nursing service of the Department of Health of East York Township. This health unit was set up as a demonstration centre for teaching purposes for medical and nursing students. Miss Carpenter has since relinquished her supervisory duties and is at present full-time on the university faculty. She has, therefore, an unusually broad grasp of all the problems affecting public health nursing. She brings a sound and informed point of view to her new chairmanship.



HELEN CARPENTER

Another new-comer this year is **Noreen Malone**, chairman of the Committee on Private Nursing. A graduate of Sherbrooke Hospital in 1935, Miss Malone had a number

of years of business experience behind her before she began her training. She has devoted herself professionally to private nursing since her graduation. She has recently been chairman of the private nursing committee of District 3, A.N.P.Q. We look to her for leadership of this large proportion of our association.

Nettie D. Fidler, director of the Metropolitan School of Nursing and a well-known figure in nursing affairs, has resumed the office which she held so successfully during the past biennium—chairman of the Committee on Constitution, By-Laws and Legislation. Miss Fidler is immediate past president of the Registered Nurses' Association of Ontario.



NETTIE D. FIDLER

H. Evelyn Mallory returns to the Executive as chairman of the very important Educational Policy Committee. Few nurses have a more comprehensive grasp of all the implications of present-day trends in nursing education than Miss Mallory. With all the promised developments of this biennium, her wise and considered leadership will be immensely valuable. She has held many offices in both provincial and the national association. She is in charge of the expanding nursing department at the University of British Columbia.

NURSING SISTERHOODS

Only two new personalities are found



Marlow, Vancouver

EVELYN MALLORY

among the representatives of the nursing sisterhoods on the Executive.

Sister Denise Lefebvre, representing Quebec, has been a member since her election as honorary secretary of the C.N.A. in 1946. Sister Lefebvre has had a wealth of experience in the matter of the evaluation of schools of nursing. With the growing consideration of this important development in our national association, sound leadership may be anticipated.



SISTER DENISE LEFEBVRE

Sister Delia Clermont, representing Manitoba and Saskatchewan, is director of nursing at St. Boniface Hospital, Man. During the 1946-48 biennium Sister Clermont, as chairman of the national Institutional Nursing Committee, steered through to completion a very worthwhile project—the compilation of a *Manual of the Methods of Job Analysis and its Related Techniques Applied to Hospital Organization*. All who

know Sister Clermont realize what a strength she will be to the Executive Committee in its deliberations.



SISTER DELIA CLERMONT

Sister Mary Claire, director of nursing at St. Joseph's Hospital, Victoria, returns for the second term as the representative of British Columbia and Alberta regions. Sister Mary Claire, who is also president of Vancouver Island District of the R.N.A.B.C., is well versed in nursing affairs. She has much to contribute to the national discussions.



SISTER MARY CLAIRE

Sister Catherine Gerard takes her place on the national Executive for the first time as the representative from the Maritimes. This new responsibility will not worry one who has been so very active in the affairs of her provincial association. A member of the R.N.A. N.S., she was chairman of their Hospital and School of Nursing Section for several years. Currently she is second vice-president of the Registered Nurses' Association of Nova Scotia. A graduate of Hamilton Memorial Hospital, North Sydney, N.S., in 1922, Sister Catherine Gerard has moved through an ascending orbit of responsibility at the Halifax Infirmary to her present position of associate administrator.



SISTER CATHERINE GERARD

Last, but by no means least, in this brilliant group of nursing leaders is **Sister Mary Grace**, representing the Ontario sisterhoods. A graduate in 1934 of St. Joseph's Hospital, Hamilton, Sister Mary Grace was surgical supervisor there for two years, followed by three years as instructor. She went to St. Mary's Hospital, Kitchener, as superintendent of nurses for a year in 1939 then returned to Hamilton to occupy that same post for four years. Following a post-graduate course in hospital administration at the University of Toronto in 1945, Sister Mary Grace assumed her present duties as director of nurses and principal of the school of nursing at St. Mary's Hospital. She has been a member of the Legislation Committee, R.N.A.O., and one of their representatives on the Ontario Health Survey Committee. During the past biennium she was a member of the C.N.A. Finance Committee. A wise counsellor and a loyal supporter of professional nursing.

Institutional Nursing

Idealism and the First-Year Student Nurse

SISTER MARGARET MOONEY, R.H., B.Sc.N.

Average reading time — 10 min. 24 sec.

"**W**HAT IS THIS BUSINESS of living all about, Sister? I can't understand why—WHY—I ever wanted to be a nurse! Before I came I visualized nursing as a grand and noble profession. I thought it would be glorious to help others, to relieve suffering, to care for little children and to soothe and comfort dear, old people, whose own folk perhaps neglected them. I knew that I would have to study and work hard to reach my ideal and I thought I could do it, too. I saw 'Angels in White' four times and I was sure that I could become (now don't laugh, Sister!) 'an angel of mercy'—understanding, efficient, and gracious—one who could command and be worthy of everyone's love and homage!

"And now, Sister, now, I am completely and utterly discouraged! I've tried to pray but it doesn't get me anywhere. No matter how hard I study and work, nobody is ever satisfied. The doctors crab and the supervisor is *so* unfair! I dread going over to the misery and suffering and petty tyranny on the ward—I could choke the bawling kids and cheerfully murder the carping old grannies. I'm so tired it isn't even funny. I think I'll just go home and have lots of fun and forget all about it!"

With this tirade, the poor youngster, who only a few months ago had stepped out in her perky uniform to conquer the world of nursing—to become a "gracious angel of mercy"—bursts into a flood of tears.

Sister Mooney has had broad experience with students in her work at Hotel Dieu Hospital, Cornwall, Ont.

While she sobs out her disillusionment, let us analyze her characteristically adolescent outburst on discovering that her ideal obviously had feet of clay.

From the abrupt outpouring of her troubles, we note that she has begun to think in abstract terms and to endeavor to classify her knowledge, perhaps scant, of the reasons for living. She realizes also that she needs guidance, that she is not able to figure everything out for herself. The normally inquisitive girl at this age is sometimes distressed, and possibly discouraged, by the overwhelming problems of life, both from within and without, which seem to loom over her with such suddenness. She longs to know the exact "why" of life, just as in earlier years she pulled her doll apart to find out why it said "Ma-Ma."

Then we see her idealism portrayed. Adolescents are often hero-worshippers and tend to fashion their conduct on models furnished by many sources—in this case by the motion pictures. She is charmed by the sensational portrayal of "an angel of mercy who commands love and homage," not envisioning the true nature of nursing beneath this artificial display. Her ideal itself is a worthy one but the motive which prompts it demonstrates her distorted sense of values. She has not yet learned to distinguish the true from the false, the real from the glittering counterfeit.

She displays abundant confidence in herself and her ability to overcome all obstacles, only to find that this confidence has been misplaced and that she has not within herself the

enduring courage required for accomplishment.

Her developing consciousness of social problems is demonstrated by her desire to help others and to relieve suffering. The awakening maternal instinct is apparent in her expressed wish to look after the little children and the neglected old people. If properly guided, this beautiful attribute, the outcome of the maturing sex instinct, accounts for the loveliest virtues in womankind—kindness, affection, sympathy, gentleness, mildness, loyalty, sweetness, self-sacrifice.

Again we note in her "Now don't laugh, Sister," the adolescent dread of sarcasm and misunderstanding, together with her maturing but elusive sixth sense, by which she feels that the situation is, in some way, slightly ludicrous.

Her lack of emotional control, apparent fickleness and petulance might, to a certain extent, be attributed to the unstable activity of the endocrine glands during this phase of her life.

And finally, in her pathetic "I've tried to pray but it doesn't get me anywhere," we realize that she needs more than all else to be imbued with that "practical sense of the divine," as Monsignor Guay calls it—that compelling realization of the necessity of an intimate, personal knowledge of Christ.

The first-year student nurse, if she is between the ages of 18 and 22 or 23, is going through an epoch of intellectual and moral reorganization following the relatively care-free life of childhood and preceding the relatively settled life of maturity. These changes are not cataclysmic in character. They are usually in the nature of a continuous development and, while it is true that the person who emerges at the close of the adolescent period is different from the one who entered it, nevertheless that self is very familiar, in its fundamental traits and habits, to the childhood self. The changes that take place during adolescence are to some extent determined by the training which has preceded it, but the emergence of a

fully-developed, well-integrated, high-principled personality depends to a great extent also on the intelligent guidance and control, leading to self-guidance and self-control, which are exercised by the agents of education during these formative years.

Daniel Webster summarized the various aspects of the problem in the accompanying lines:

If we work upon marble, it will perish.

If we work upon brass, time will efface it.

If we rear temples, they will crumble to dust.

But, if we work upon men's immortal minds,

If we imbue them with high principles,

With a just fear of God and love of their fellowmen—

We engrave upon those tablets something which

No time can efface and will brighten and brighten

To all eternity!

In analyzing the sobbing nurse's direct attack on life in general and nursing in particular, we realize that it is due, in part, to the period through which she is passing. But we must also take into consideration the great and almost overwhelming danger with which the youth of today have to cope—the prevailing lack of faith in this age of materialism! The spirit of communism is undermining all cultural and religious freedom. A "more potent source of danger is found in the development of an educated body of thought which regards men merely as units of a sociological body, with no further destiny than that of a comfortable earthly existence and no other salvation than that of freedom from exploitation and superstition." Living in an atmosphere in which these false theories are so blatantly expressed, the young woman of today can hardly be expected to enter the field of nursing with the high and Christ-like ideals which should belong so peculiarly to this profession.

Not only are her ideals tinged and vitiated by the humanistic spirit of the world but, with the advancements of medical science, greater and greater demands are being made upon her

mental and physical powers, so that the strain of constant study and arduous duties during long hours may also prevent her from realizing that her life has a higher, spiritual aspect. Yet withal, she is ever haunted by the vision of an ideal life because within her there is the possibility of it.

How are we going to comfort the child in her and at the same time stimulate and re-animate the blossoming adult? Effort and struggle are necessary for development but development is made easier by having ideals. How shall we modify, not destroy, her present ideal and substitute a worthier motive to protect her against the lure of present pleasure and to hold her to the often dreary task of working towards a glorious but distant goal?

The aim of character training should be to inspire her to act virtuously, not because she is being watched or forced but because she wants to do so. She must be imbued with a high motive which will inspire all her specific ambitions, since at this age she is now intellectually capable of appreciating the value of ideals. A noted author has said, "Fitting the mind for the reception of truth, rather than filling it with knowledge, is the proper object of education. A girl may succeed as a nurse, yet fail to be a woman—thus fail in the ultimate purpose of life."

What fundamental ideal, then, shall we propose? Will altruism suffice? "An appeal for self-sacrifice on the score of the welfare of future generations will often elicit the cynical response—What has the future generation done for me?" Nor is self-respect a potent motive on which to found ideals, for self-respect may be sacrificed to self-seeking.

Purely human motives are inadequate. There is only one motive strong enough to curb individual selfishness, human pride, and longing for pleasure, and that is—the religious motive. The great advantage of a truly Christian education lies precisely in the

fact that it keeps before youthful eyes models that are concrete and at the same time completely deserving of imitation. In striving to imitate the virtues of these models the nurse will find the only satisfying answer to her query—"What is this business of living all about?"

*Thou must be holy—day by day impress
This lesson deeply on thy youthful heart;
Wait not till dark visions of distress
Shall cloud thy light and bid thy joys
depart.
Virtue alone can guide to ports of peace,
Virtue alone can teach thee to endure;
This treasure every day and every hour
increase,
Be virtue thine, the rest is all secure.*

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We exaggerate misfortune and happiness alike. We are never either so wretched or so happy as we say we are.—BALZAC

Public Health Nursing

The Staff Studies Nutrition

LORRAINE MILLER

Average reading time — 14 min. 24 sec.

THE BLUE-CLAD NURSE carefully removed her shoes and followed her guide into the Sikh Temple. There were no chairs, so rather than sit cross-legged on the floor she stood in stockinged feet on the hot-air register. This was the warmest place and a favored spot.

This departure from the usual routine was one result of a staff conference of the Vancouver branch of the Victorian Order of Nurses. A "suggestion box" had revealed the desire of the staff nurses for a broader knowledge of nutrition. After due consideration a program was planned to meet the expressed needs of the group. Conferences were scheduled for one afternoon each month.

The first discussion period on *racial and religious beliefs and superstitions as they affect dietary habits* was most interesting. Four nurses presented papers on the habits of the Chinese, Hindu and Sikh, Jewish, and Central European groups. Canadian diet survey findings were used for comparisons. Staff members visited the Sikh Temple, the Chinese Y.W.C.A., and interviewed many of the families in the district in their search for information. They were surprised at the interest and enthusiasm their research aroused.

Many nationalities in Canada still adhere to racial and religious ideals in their dietary habits. Surveys reveal that these people prefer special dishes made from recipes handed down through generations. Such adherence to food habits may seriously influence the health of the people.

Miss Miller is educational director with the Vancouver branch of the Victorian Order of Nurses.

Studies have shown that there is considerable malnutrition in our midst. This is probably due as much to ignorance and indifference as to inaccessibility, environment, and economic status. There is sufficient food available and consumed to provide everyone with an adequate diet. It is essential, however, to have a knowledge of food, as well as the actual food, in order to have good health. In spite of our apparent plenty, up to 25 per cent of certain groups are underfed in specific respects. Rickets is still fairly common. Nutritional anemia results from inadequate iron in the diet. Iodine is lacking in many areas.

Surveys of the Indian and Eskimo have shown marked forms of malnutrition. Though some of the established eating habits of the racial groups are causing serious concern, others are found to be capable of maintaining health and well-being.

CHINESE

The Chinese in the larger communities keep many of their national food habits. Some of their oldest food customs are still good health rules. It was interesting to learn how the foods they use and the state of their nutrition compared with Canadian standards and ideals.

There are some who still regard the cow as sacred and will not eat its flesh. Many believe cold foods are unhealthy and that raw vegetables and fruits cause sickness. They are fond of green rather than root vegetables and they do not like them overcooked. The Chinese do not care for sweet puddings or stewed fruits but like citrus fruits. Most of the cooking is done on top of the stove; they rarely

make use of the oven. Most of the meats and vegetables are fried in deep fat, boiled or steamed. Thick soups of meat stock containing all types of vegetables are favored.

Some of the foods used frequently in China are also eaten here. These include: dry lotus seeds, birds' nests, rice, millet, bamboo sprouts, sharks' fins, beans, eggs, water-lily roots, seaweed, noodles, soya beans, green vegetables, rice spirits, condiments, and preserved fruit. No meal is complete without some meat, fish or fowl. Fish may be salted or fresh and shell-fish also are used. Meats include mutton, pork, and some beef. In addition, they eat a great deal of chicken and duck. The bill of a duck or the head of a hen are regarded as delicacies. Anyone giving a gift of a fowl must give the whole bird. Milk used in Chinese cooking is usually condensed or malted.

A recent survey of 157 Chinese children in Vancouver revealed the following facts:

It was difficult to find a Chinese family with an entirely Chinese diet. The majority have adopted many of our food habits. They have substituted foods which meet with the recommended dietary allowance of Canada's Food Rules and which suit their customs. It was agreed that the better features of their national diet should be retained but strengthened with the addition of more Canadian food-stuffs.

One of the findings of the Vancouver survey was that approximately 15 per cent of the children had insufficient calorie intake. They ate little bread and potatoes but received adequate proteins. Many of them had dental caries, poor posture, and were slightly low in iron. Many had low hemoglobin but not one had a vitamin A deficiency or thyroid hypertrophy. Their thiamin intake was deficient. Four lacked riboflavin while three children showed evidence of rickets.

Nutritional deficiencies were mainly due to insufficient food intake and lack of specific protective foods. Underlying causes of these deficiencies were found to be poverty and ignorance. Many Chinese children are still not eating some foods which are necessary for full growth and

health. Using Canada's Food Rules as a standard, the majority do not drink enough milk, eat enough potatoes, whole-grain cereals, bread and butter, or have adequate breakfasts.

SIKHS AND HINDUS

Their dietary habits vary in many ways. Again we see the adherence to racial and religious teachings which the elders brought with them and which they are passing on to their children. The Sikhs are not forbidden to eat meat but they are not habitual meat-eaters. Their diet is largely vegetarian, consisting of corn rotis, unleavened bread, boiled vegetables, fruits, plenty of butter and curds, milk and whey. They customarily do not eat beef but may eat mutton and pork. They seldom use our bread, except for sandwiches. Macaroni and rice are used frequently in making cakes and puddings. For spices they prefer chili, curry, and salt.

Among the older civilizations food preparation is part of the ritual of life. Reverence for food has made these people greater gourmets than most Europeans or Canadians. The Hindu believes that food was created for man by a Supreme Deity—thus the art of cooking is a sacred ceremony. References to food are found in Hindu Holy Books dating back to the fifth century, A.D. Food was then classified according to its nutritive value, flavor, and esthetic appeal. In the Hindu prayer-book foods are divided into three categories:

1. Foods conducive to longevity are invigorating, nourishing, and savory. These foods are pleasing to people of truth.
2. Pungent, bitter, very acid, or over salty foods, which are apt to be injurious, appeal to those of passion.
3. Stale, rotting, and impure foods bring gloom to those who eat them.

Many subtle dishes are evolved because food has such a high place in their lives. Curries are not hot or fiery but have a pleasant flavor and are very tasty. There must be perfect blending of condiments. The diet of the poor consists mainly of cereal dishes but the rich use a great variety

of elaborate combinations. Kedgerree, pilan, and curries are among their main dishes.

Kedgerree is a combination of rice, green vegetables, green ginger, lentils, and spices. These are all cooked together and can be eaten plain or with vegetables, a curry, or mango chutney. This dish can be cooked crisp by using butter.

Pilan consists of rice, onions, raisins, almonds, spices, and butter, with lamb, beef, prawn, or shrimp. Hard-cooked eggs may be added.

Curried dishes include those made with chicken, mutton, beef, pork, lamb, shrimps, and fish. Vegetable curry is made with potatoes, tomatoes, onions, and egg-plant. Seminole molds and sweets with raisins are used as desserts. Dried fruits and pickles are used frequently. They use sour cream and milk a great deal. Candies are made from milk curds and are "really very good."

JEWISH

The report on their food habits was presented by one of our Jewish nurses. She was able to tell us much about the food habits of her race and to explain some of the religious beliefs as they affect their diet.

It was interesting to learn that all animal foods must be killed and prepared in a prescribed manner. Blood was regarded by ancient Hebrews as a vital part of the animal which must be given back to God. The Jews have excluded pork from their diet since early Biblical days. Meat is salted for half an hour and cooked for an hour. We wondered how this could affect its food value. Only fish that have fins or scales may be used. No shell-fish are acceptable. Meat and milk may not be eaten together. This precept originated from the ancient law forbidding the boiling of a kid with its mother's milk.

During one of the most important holidays, the Passover, no leavened bread or its products may be used for eight days. Cutlery, dishes, and cooking utensils must be sterilized or a new set kept for use during this period.

The Jewish race appears to have a high incidence of diabetes. It is felt that this is due to the richness of the food, especially pastries and cakes

which are used in abundance. Pickles and "sours" are also used in large amounts. Jewish people use rye and whole-wheat breads.

Orthodox Jews adhere to their racial and religious dietary habits. Their diet, however, seems adequate and, apart from the trend to a high carbohydrate intake and high incidence of diabetes, does not present too much of a problem.

FOOD BUYING

Our first specialist, Mrs. Margaret Henderson, B.Sc., Home Economics director of the *Vancouver Daily Province* "Kitchen," spoke on "Stretching the Food Dollar." She gave us many helpful hints, such as:

Buying perishable food-stuffs in small quantities will prevent wastage. Old people should have a good dinner every day. Meals should be planned for variety and to avoid "eternal frying." Turnips, rich in vitamin C, were advocated. Rice can be used as a vegetable; fats should be saved for cooking. Cheese, parsley, and bean sprouts are all valuable, cheaper foods. Vegetable water should be saved and made into milk soups. Cereals should be used more widely. The lowly sardine is a good source of iodine. If a pressure cooker is available it helps to save food dollars. Bones are a good source of gelatin. They can also be used to make excellent soup and provide energy. Gelatin desserts are especially good for the older age groups. "Last but not least," said our speaker, "hobbies help to create an appetite, something to keep us busy and happy. Pleasant, cheerful surroundings make for better appetites and pleasant eating."

BUDGETING

Our next two specialists, Misses Ross and Crocker, nutritionists with the Metropolitan Health Committee of Greater Vancouver, discussed with us plans for budgeting in the low income group. They discussed, too, a survey they had made on allotments for food and living for persons on Social Aid. Rising living costs bring difficulties and it was felt larger allowances were needed to maintain ade-

quate diets and living conditions. We were glad to learn that special allotments are now provided for patients in Vancouver who are on special diets and who are receiving Social Aid.

DIET THERAPY

The final conference, prepared by the staff nurses, included a panel discussion on "Newer Trends in Diet Therapy." We had as our guests two dietitians from one of our large hospitals, who had assisted the nurses in their research and preparation.

We learned that folic acid, part of the B-complex group, is valuable in the treatment of pernicious anemia. The newly discovered vitamin B₁₂ is also proving effective in treating this disease. Recent experiments indicate that large doses of vitamin A speed up maturity and delay aging, thus lengthening the "prime of life." Vitamin E is being used in treating coronary thrombosis. It appears that too large doses of vitamin D are actually harmful, both for babies and adults.

It was rather disconcerting to learn that a new group of substances known as "antivitamins" has been discovered. These, as the name indicates, counteract the vitamins. It is probable that the dietary value of many foods will require reevaluation because of the presence of these antivitamins.

Reports on experiments in self-demand feeding were of great interest in the discussion on infant feeding. The usually accepted feeding schedules are unsuitable for many infants. Each baby requires individual planning. The earlier addition of solid foods in the infants' diets was noted as well as the acceptance and reaction to these foods by the babies.

The use of fluorine to reduce dental caries and the present trend toward topical application as the method of choice was discussed. Mention was made of survey reports on the use of fluorine in Canadian school dental services.

In the nutritional treatment of disease, the chief topics discussed are listed briefly:

1. The use of protein therapy in treating cirrhosis of the liver.
2. The trend toward increased use of

protein therapy following surgery to prevent post-operative complications.

3. The effective use of vitamin B to control uterine bleeding and other similar therapies based on the frequent association of vitamin deficiency with endocrine deficiency.

4. The present preference for underfeeding rather than overfeeding. This stems from findings that debilitating diseases occurred less frequently in Europe in the period of underfeeding during and after the war.

5. The Kempner-Rice diet for hypertension. Since this is an inadequate diet, consisting only of rice and fruit juices, it can be continued for only three weeks at a time.

WHAT DID WE LEARN?

The staff all felt they had learned a great deal from our planned study of nutrition. We realized that working with racial and religious groups requires tolerance and understanding. Some of their ideals and ideas are of ancient origin and we must adapt our teaching to meet them. We learned of the availability of specialists whom we could consult to make us better able to meet our patients' needs. The association with these people stimulated interest in each other's problems. It was "good public relations." We felt we had acquired up-to-date knowledge of newer dietary treatments. The points about budgeting and financing could be used by us all. Each staff member had an opportunity to take some part. We all felt it was a very worthwhile effort, both for the nurses and for the patients who would ultimately benefit.

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Industrial Nurses Confer

A conference for industrial nurses, sponsored by McGill University and The Association of Nurses of the Province of Quebec, was held on May 15-17, 1950. The need for such a conference has been felt for some time. The meetings were well attended and the subjects well chosen.

There were 119 nurses registered, representing 76 industries. There were 13 honorary guests. When registering, each nurse was given a program and an identification card on which was printed her name and the company she represented.

While the weather at the beginning might have been more favorable, still it did not in any way affect the attendance. The meetings proved very popular. We all met many old friends and made many new ones.

All sessions were held at the School for Graduate Nurses. Miss Ann Peverley, assistant professor, in the absence of Dr. Marion Lindeburgh, presided. She extended a very hearty welcome to all those present.

Miss Mildred Walker, nursing consultant, Industrial Health Division, Department of National Health and Welfare, was the first speaker. Her topic was "The Role of the Nurse in Industry." She pointed out that we must all recognize that the industrial nurse needs certain qualifications for success and must be willing to accept responsibilities; that she is in a strategic position to promote good health of the worker, not only in the industry in which she works but in the community as well.

Dr. C. D. Shortt of the Canadian National Railways spoke on "Emergency Care." He emphasized the importance of all nurses in industry, especially those working alone, securing Standing Orders, prepared and approved by the plant physician. He outlined the treatment of injuries and diseases arising out of employment.

The afternoon session was presided over

by Miss Walker. Dr. Paul Guenette, industrial consultant, discussed "The Relation of the Industrial Nurse to the Workmen's Compensation Board." He defined the legal, insurance, administrative, and technical aspects of the Board. This was followed by a very friendly talk by Dr. R. G. Ratz, chief, Civil Service Health Division, Department of National Health and Welfare, on "Interviewing and Counselling." He said a nurse working in industry today had to be "Jack-of-All-Trades." She should be observant, a good listener, and learn to utilize her own ability. She should be able to give advice in such a way that the employee is able to cope with his own immediate problems and help himself with any future ones that may arise. Interviewing should always be done privately and information obtained treated confidentially.

On Tuesday morning, Miss M. Brogan, nursing supervisor, Bell Telephone Co. of Canada, Montreal, and Dr. W. H. Cruickshank, medical director of the same company, spoke on records. They stressed the importance of accuracy to provide valuable information as to whether the reported cases are industrial or non-industrial. Such records are useful from a statistical point of view in compiling monthly reports for the Safety Department and Management. They should be strictly confidential and kept in the Medical Department in locked files.

Dr. F. J. Tourangeau, director, Division of Industrial Hygiene, Quebec Ministry of Health, spoke on "The Industrial Nurse and Community Relationships." He told us about the specially equipped laboratory right here in our own city with well-trained technicians who are willing to visit the various industries at any time and test the air for impurities. He stated that the nurse should have a thorough knowledge of all social agencies

(Continued on page 832)

Aux Infirmières Canadiennes-Françaises

Service Social à l'Hôpital

SOEUR STE-FABIENNE, S.C.Q.

Average reading time — 10 min. 24 sec.

LE TRAIT distinctif du Service Social à l'hôpital est l'orientation de ses activités vers la guérison des malades. Laissé à ses seules ressources, il lui serait téméraire de tendre à cette fin. Ses efforts se justifient et deviennent efficaces en autant qu'ils sont un apport à l'action conjuguée de tous les services dont l'ensemble constitue cet organisme complet qu'est l'hôpital. Sa participation consistera d'abord à apporter au clinicien les résultats d'une étude approfondie de la personnalité du malade ou d'investigations judicieuses de son milieu social; toutes choses susceptibles, dans certains cas, d'orienter un diagnostic ou, tout au moins, de l'appuyer.

Mais, il lui sera plus souvent donné de collaborer à la guérison du malade en le libérant le plus complètement possible des problèmes sociaux déjà existants chez lui où dont la maladie a précisément été le point de départ.

C'est devenu un adage populaire que le bon moral chez le malade est une condition essentielle à son parfait rétablissement. Saisi de cette réalité, le Service Social Médical veut user de tous ses moyens d'action pour lui procurer un état de quiétude qui favorisera l'effet thérapeutique des traitements médicaux, voire, des traitements chirurgicaux auxquels il sera soumis.

Ce n'est pas à des infirmières qu'il est nécessaire de fournir les preuves de cet avancé puisque leur vie professionnelle leur en apporte journellement l'évidence concrète. Que de fois elles sont les confidentes des inquiétudes et des soucis qui tenaillent ceux

qu'elles comblent de leurs attentions et à qui elles prodiguent leurs soins professionnels avec toute l'intelligence, la conscience, et le dévouement dont elles sont capables. Hélas! Souvent, en dépit de ce maximum de bonne volonté et de don d'elles-mêmes, elles sont forcées d'admettre leur impuissance à guérir certaines plaies très profondes sur lesquelles elles ne peuvent que verser le baume d'une parole sympathique ou d'un encouragement. Leur cœur généreux voudrait faire plus et mieux, mais cela demanderait du temps et déjà elles doivent s'ingénier à faire entrer dans le cadre de leurs journées les multiples obligations de leur devoir d'état.

Aussi, ne peuvent-elles qu'applaudir à l'apparition d'une profession nouvelle venant compléter une oeuvre forcément inachevée chez certains malades.

Mais, qu'est-ce donc que cette innovation et quels sont ses moyens d'opérer de telles merveilles?

À l'instar de tout service social, celui qui a l'hôpital pour champ d'action cherche par des techniques éprouvées à découvrir la nature et l'origine des problèmes susceptibles de troubler un milieu ou de mettre le désarroi dans un individu.

Cette connaissance acquise et approfondie, une ligne de conduite est adoptée à l'effet d'apporter le remède adéquat à la situation anormale.

Elles sont nombreuses et variées ces situations anormales soumises à la compétence et au dévouement de l'assistante sociale-médicale.

C'est, par exemple, un père de famille soudainement réduit à une impotence totale pour plusieurs mois par un accident ou par une maladie

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subite. Pour lui, les souffrances physiques passeront vite au second plan, faisant place aux soucis financiers. Son salaire supprimé, cela signifie pour sa famille: privations de toutes sortes, vie pénible, misérable et, peut-être, congédiement du loyer.

L'intervention du Service Social dans ce cas aura comme heureuse conséquence de faire bénéficier ce foyer des ressources communautaires et de rendre au père alarmé un optimisme bienfaisant.

Tantôt ce sera une jeune fille chez qui les examens ont démontré l'existence d'une tuberculose pulmonaire contagieuse. La révélation de ce diagnostic et la perspective d'une cure dans un sanatorium ont pour elle le sens d'une tragédie. Ce n'est que par des entrevues répétées et sagement dirigées que l'assistante sociale l'amènera à regarder en face la réalité et à se soumettre aux exigences de son état physique actuel.

Aujourd'hui, le médecin trouve "toute en larmes" une de ses malades, mère de famille, atteinte d'une lésion cardiaque grave. La cure médicamenteuse et le repos ne sont qu'amorcés mais la maman voudrait retourner auprès de ses enfants. Elle s'ennuie trop à l'hôpital pour accepter d'y séjourner plus longtemps! Mais, la psychologie du chef de clinique a vite fait de deviner sous ce prétexte une souffrance morale beaucoup plus profonde. Aussi, après la visite, on lira à la page des ordonnances: "Faire voir la malade par le Service Social."® Après quelques entretiens la pauvre mère a donné toute sa confiance et, presque spontanément, elle avoue que son véritable tourment c'est l'insécurité morale de sa jeune famille pendant son absence et la lourde responsabilité laissée à sa fillette de 13 ans. Alors, une visite faite au domicile de la malade permet à l'assistante sociale de se rendre exactement compte des choses et des démarches sont aussitôt commencées dans le but d'assurer la présence d'une personne responsable auprès de ces jeunes enfants.

Maintenant la malade est rassurée et continue de profiter des avantages

de l'hospitalisation. L'assistante sociale ira chaque semaine s'enquérir de la situation et s'assurer que rien n'est en souffrance à la maison. Les bonnes nouvelles données à la malade lui apporteront une sécurité favorable à son rétablissement.

Ajoutons à ces quelques exemples le cas des malades à réhabiliter au sortir de l'hôpital à cause d'une infirmité les mettant dans l'impossibilité de continuer leur travail habituel; celui des jeunes étudiants devant interrompre leurs études par, une longue convalescence imposée par une affection pulmonaire récente et à qui il faut assurer les leçons d'un professeur bénévole; celui de la réhabilitation des filles-mères venues de milieux suspects d'où il est urgent de les retirer.

Il y a aussi, parmi les malades chroniques, les diabétiques, les cardiaques, etc., qu'il importe de suivre après leur hospitalisation. Sont-ils fidèles à leur régime? Prennent-ils régulièrement leurs injections d'insuline? Persévèrent-ils à suivre la médication prescrite? Ont-ils l'argent nécessaire pour se procurer ces médicaments? Auraient-ils besoin en cela de l'assistance du dispensaire de l'hôpital? Leur état semble-t-il s'aggraver ou s'améliorer? Autant de points dont la solution immédiate peut aider à prévenir une récurrence grave. Et c'est peut-être ici surtout que le rôle de l'assistante sociale médicale prend toute sa valeur. Par son intermédiaire, le médecin restera en contact avec les malades retournés à leur foyer et le traitement commencé à l'hôpital sera poursuivi et contrôlé.

Sans l'action de cette agence de liaison, le temps ramènerait tôt ou tard à l'hôpital ces malades dans un état extrême alors qu'il serait peut-être difficile de les arracher à la mort.

En plus de se donner à toutes ces activités, le Service Social de l'hôpital verra à pourvoir les malades indigents des appareils orthopédiques requis dans certains cas. Il leur procurera des moyens de transport pour le retour à la maison et en assumera les frais si nécessaire. Il se chargera de la correspondance des malades éloi-

gnés de leur famille. Il organisera des loisirs pour les hospitalisés et leur procurera des lectures saines et agréables.

Cette "façon moderne de faire la charité" comme on a si bien désigné

le Service Social est un complément opportun à la science et au dévouement du personnel hospitalier.

Avec sa collaboration, l'hôpital réalisera un peu plus son bel idéal: Soulager le malade et . . . le guérir.

In Memoriam

Julia Ellen (Sharpe) Affleck, widely known in nursing circles, died at her home in London, Ont., on June 26, 1950, after a brief illness.

* * *

Bessie Louise Babbitt, who graduated in Newport, R.I., died in Fredericton, N.B., on July 11, 1950, after an illness that lasted eight years. Miss Babbitt served overseas as a nursing sister during World War I. She was head nurse of the D.S.C.R. Hospital in Fredericton at the end of that war. She served in the Jordan Memorial Hospital in Albert County and also had considerable nursing experience in the United States.

* * *

Florence Emily Beck, a graduate with the second class (1894) of the Montreal General Hospital, died in Montreal on August 6, 1950, at the age of 84. Miss Beck served on the staff of the M.G.H. for many years, later going into private practice. She retired from active work some 15 years ago.

* * *

Lillie Boyle, who was a member of the first graduating class of the Ottawa Civic Hospital in 1925, died on July 17, 1950, after a lengthy illness. She had nursed in Ottawa until her retirement five years ago.

* * *

Stella Belle (Taylor) Clark, a graduate of the Nova Scotia Hospital, Halifax, died in Nanaimo, B.C., on May 26, 1950, at the age of 69.

* * *

Lucy Ermina Clow, who was a member of the first class to graduate in 1895 from the Brockville General Hospital, died in Brockville on July 11, 1950, at the age of 78. Miss

Clow was assistant superintendent of nurses at B.G.H. a number of years ago. She was very active in Red Cross work during the war years.

* * *

Jessie Ellen Grant died in New Glasgow, N.S., on July 9, 1950, in her 79th year. A graduate in 1906 of the Massachusetts General Hospital, Boston, Miss Grant occupied many important positions in hospitals in the United States. She went overseas in 1917 in command of one of the largest units of nurses sent to France by the U.S. Army. For some months during a visit to Canada in 1920-21, Miss Grant was superintendent of nurses at the Victoria General Hospital, Halifax. She was also director of nursing at the Winnipeg General Hospital for several years. Miss Grant retired in 1943 and four years later returned to New Glasgow.

* * *

Millicent Keary, who graduated from St. Paul's Hospital, Vancouver, in 1932, died on August 3, 1950, of an illness that had lasted for several years.

* * *

Hilda Meikle died suddenly in New Glasgow, N.S., at the age of 65. Miss Meikle was a past president of the Pictou County Nurses' Association and, though retired from active duty, was very much interested in the work of the Children's Aid Society.

* * *

Alice Marguerite (Lecours) O'Shaughnessy died on July 27, 1950, in Regina. A graduate of the Regina Grey Nuns' Hospital in 1942, she served as a nursing sister with the Royal Canadian Navy during World War II.

Certain thoughts are prayers. There are moments when, whatever be the attitude of the body, the soul is on its knees.—VICTOR HUGO

Counselling for Nurses

WILLIAM G. BLACK, PH.D.

Objectives: The purpose of counselling is to assist individuals in order that they may make better adjustments to life and become more efficient in their vocation and happier in their personal living.

Development of counselling: There have been remarkable developments in this field in recent years, both in Europe and America. These developments include research and experiments in a great variety of tests and counselling techniques. Furthermore, a large body of useful literature has been written both in periodical and book form. Many magazine articles and books on testing and counselling have a special application to the field of nursing. Applications from the science of psychology have been particularly fruitful with respect to counselling. These have been used very extensively by psychiatrists and psychologists and have been employed in a number of specific fields, such as counselling in industry. It would appear that they would be just as fruitful in the field of nursing as in any other field.

Limitations of testing and counselling: It is not claimed that testing and counselling techniques will guarantee solutions to all vocational and personal problems. However, they have been found so successful that one cannot but be enthusiastic about their use. If they give genuine assistance in even 50 per cent of the cases, their use is amply justified.

Techniques and materials used: During the work conference various types of interview techniques were described and discussed, also various types of tests and records. Attention was given to the importance of follow-up work, since it was realized that in most cases single interviews or single test experiences are inadequate. It soon became apparent that anyone participating in counselling should be acquainted with a large variety of techniques, so that she would be able to choose the proper types for each individual client. Since no two clients have exactly the same problems, the techniques employed will necessarily differ.

Stages of life for counselling: As the discussions developed, it became clear that counselling is a process which has many forms and covers many years. Counselling for prospective nurses is obviously very

important at the junior high school and high school level. It becomes more significant still at the college level for those students who go on to college before taking nursing training and it becomes vitally important during the preliminary and training period at the school of nursing. It is also necessary for those who have finished their training and who are on the staff of hospitals, or for those who are doing public health work, or who are in such fields as industrial nursing, both from the vocational and the personal point of view.

Counselling for patients: Not only is it necessary that prospective and staff nurses should be able to obtain counselling when such is needed but it is also important that patients should receive counselling. The total therapy of a patient obviously includes not only physical treatment but also aid in making personal adjustments to life. Since nurses come into such close contact with patients at critical times in their lives, they have great opportunity to give both physical and mental aid.

Who should participate in counselling: In the modern high school, specially trained counsellors for boys and girls are assigned to this important work. In a nursing school, the members of the staff all have their part to play in the counselling process but some one member should be particularly responsible and should have received special training in the appropriate techniques. On the hospital staff the same arrangement should be found—namely, that one member of the staff, whether a nursing supervisor or head nurse should be available for vocational and personal counselling and to this end should have received special training.

Facilities for training in counselling: It is obviously impossible for most busy staff members to take much time off in order to secure a long program of counselling training. However, there are many practical methods whereby brief but effective training may be obtained. Among these practical methods are the following:

- (a) A course on psychology of testing and counselling given by a city night school (such a course could be made available in most of the large cities of Canada).

- (b) A correspondence course given by the provincial Department of Education.
- (c) A summer school course given by the nearest university (many such courses are available in university summer session programs).
- (d) A local institute, provided by either provincial or local nursing associations.

If no course of this kind is available in your particular area, it is suggested that you request one of the above authorities to provide it. Most authorities are only too pleased to organize a course of this nature, if 10 or more candidates signify that they wish to take it.

Qualifications of nursing counsellors: Since most nursing counsellors will have many other duties to perform, they cannot be expected to have the long and thorough training demanded for a full-time high school counsellor. However, if they have taken

one or two courses on Psychology of Testing and Counselling, they should gain quite an insight into problems and techniques. Fully as important as the taking of a course is the possession of such personal qualities as common sense, sympathy, patience, tact, and in general a helpful, kindly, constructive attitude.

Use of outside resources: In most centres where nurses do their work, it is possible to obtain the cooperation of highly trained psychiatrists and psychologists, who would be only too pleased to assist with their advice in the working out of a practical counselling program for nurses.

Coordination: Since there are so many people taking part in counselling and since there are so many forms of counselling, it is essential that the program be organized and coordinated. Therefore in each hospital or nursing training school, some one person should be chosen to act as the organizer.

Evaluation and Accreditation Work Conference

SISTER MARY CLAIRE

The introduction of the conference on the Evaluation and Accreditation of Schools of Nursing consisted of a panel discussion which attempted to give the whole group a better understanding of the topic under consideration. The consultants participated in this panel which was under the direction of Miss Margaret Street. Miss Virginia Olcott, from the University of Washington, gave valuable assistance and we wish to avail ourselves of this opportunity to thank her for her contribution. The panel was followed by a brief summary of the techniques of work conference during which Miss Dorothy Riddell pointed out some of the factors conducive to success and some of the pitfalls of this type of meeting. This was the preventive aspect of our program.

Three groups were organized with leaders, secretaries, and observers. On the first day the groups centred their study on the effects of such a program on: (1) the administrator and the hospital board; (2) the school of nursing and its faculty; (3) the nursing service.

It was generally agreed that such a program would be stimulating to both the school

and the hospital and would, therefore, tend to improve both nursing education and nursing service.

The second-day program opened with a skit the purpose of which was to give a brief concept of: (1) Preparation for evaluation, etc.; (2) cooperation of faculty in preparation for visit; (3) the function of the visitors; (4) interpretation of visitors' reports. The groups' contribution was more productive on this second day and the members became more conscious of their objectives.

On the third day the groups were shown the Statistical Pattern Map and the Evaluation Pattern Map used by the Canadian Sisterhoods in the evaluation program they have initiated. The peak load of work was done on this day, which was to be expected. The registrants were beginning to know each other and to know and understand what they were aiming at. Suggestions were made by each group. These were similar in content although the method of approach differed somewhat. The groups support the principle of evaluation and accreditation of schools of nursing under a voluntary scheme and suggest:

1. The appointment of an educational consultant for the C.N.A. to assist with the organization and the implementation of such a program.
2. That programs be initiated by local groups in various centres in each province to give general information regarding this program to nurses across Canada.
3. That, during the biennium, the C.N.A. arrange for persons who are well informed in evaluation programs, to attend provincial annual meetings in order to participate and lead the discussions regarding this program.
4. That this preliminary educational campaign be followed by institutes across Canada under the sponsorship of the C.N.A. and the direction of the educational consultant.
5. That steps be taken to implement such a program as soon as possible.

The French Work Conference

SUZANNE GIROUX

First of all, I want to thank the Canadian Nurses' Association for having organized a French program at the 25th convention. It was of great satisfaction to my French colleagues and myself.

In the French workshop we adopted the same topic as that being used by our English confrères, namely "The Nursing Team," which in French to give an exact translation would mean "The Nursing Crew." Just by using the word "crew" the plan of our workshop was outlined and the comparison of the health agencies to a ship, and personnel to a crew, was a happy one that we carried out during the three days.

Our group were not all familiar with the workshop technique, nor too well prepared to study this problem; some of the participants were hospital nurses and others public health nurses.

1. During the first day we studied

briefly the aim, functions, and composition of the crew.

2. The second day—relations between the different categories of the team, inside and outside the organization.

3. The third day—standards and requirements.

Recommendations were made, one of these being, "To encourage the study of care to be given to patients." It made us feel very proud when this morning the delegates were asked to vote on a similar recommendation. We do believe that the twelve members of our workshop have gained some valuable information in the general discussion that took place and that we did succeed in stimulating their thinking. The exchange of observations with the group of the English workshop was most interesting.

The invaluable help of Miss A. Girard on public health questions was appreciated.

Job Analysis of Nursing Positions

B. H. PETERSON

There were 55 participants representing a good cross-section of the various nursing fields in this workshop which was divided into four groups of 12 to 14 members.

The first day was taken up with the orientation of the members because most of them were not acquainted with the subject. I do

not make this observation in a derogatory manner because nursing supervisors and other administrative staffs in the nursing field are no different from those in other fields of endeavor. During the first day, the consultants were frequently asked questions and discussions in the groups were not always

kept to the point. Sometimes the emphasis was placed on "man analysis" rather than "job analysis."

During the second and third day, members were looking for new ideas which they might use to improve their respective organizations. Many questions were necessary in order to orient the members' thinking to the subject in relation to nursing. The majority soon realized that they were not sufficiently equipped to discuss job analysis and openly admitted their short-comings. This was especially true when the discussion reached the point where job analysis divulged the weaknesses in an organizational structure. However, in spite of these drawbacks, the members quickly established a sense of belonging to their respective groups and, with few exceptions, everyone participated.

Here are some suggestions which were offered by the participating members. It is felt that group leaders should receive previous instructions and encourage the participation of each member. This could be done by direct questioning. It is also felt that pre-conference preparation of members would add to the contributions which they might make during the discussions. From a perusal of the reaction slips, it is quite apparent that many new ideas were suggested and that the majority of members were enthusiastic about the possibilities of the subject and its application to administrative problems. There is no doubt that the members were eager to learn more about job analysis. There was a strong indication that they were going to pursue the subject further and, if given the opportunity, make use of it.

One of the most important conclusions

arising out of the sessions was the awareness of the members that, unless further training and consideration is given to supervisory and administrative duties, the nursing staff would soon be supplanted by persons with these qualifications. Job analysis would show up these weaknesses and aid in clarifying lines of authority and responsibility.

In the face of rising costs and higher standards, it is a challenge to the nursing profession to take its rightful place in the administration of institutions requiring their services. Although service to humanity is the first requisite of your profession, efficient organization, involving modern methods and procedures, must be established if that service is to meet today's needs. Job analysis has many uses, but if the only benefit derived from its application was to clarify lines of authority and duties of each position in an organization, the results would be a ten-fold return on the efforts put forth.

One participant made the comment that there was no time to do a job analysis because the sick must be looked after. I am sure that you all realize the necessity for training staff and, if a supervisor is to take her rightful place in the organization, she must take time to train, to develop, and to delegate responsibility to her subordinates. Why not diagnose your organization by job analysis? Perhaps it is ill. Job analysis can expose the malady. Then by applying the principles of sound organization and supervision, a cure can be effected. Here is an opportunity for the Canadian Nurses' Association to lead the way through research and education in this valuable technique of modern management, as applied to the nursing field.

Methods of Evaluating Student Progress

HELEN PENHALE

On behalf of the 53 nurses registered for this workshop I thank Miss Nash and the Executive of the Canadian Nurses' Association for making it possible for us to learn something of group dynamics and for the opportunity to participate in a work conference.

Student progress is concerned with measurement in three major fields—the basic sciences, the nursing arts, and the clinical area. Each

of these major fields was considered by a sub-group.

In our preliminary discussion it was agreed that through better means of evaluating student achievement will come an improvement in the education and hence the graduation of better nurses. To be able to give the best nursing care on a professional level the nurse must become proficient in:

1. Understanding the reasons for and the

means by which nursing care benefits the patient.

2. Performing nursing skills so that the patient benefits during safe care and so that the nurse continually does a finer piece of work.
3. The acquisition of the attitudes and refinement of a sensitive and imaginative person entrusted with the direction and teaching of healthful living.

Each of the sub-groups discussed the seven steps in an evaluation procedure, beginning with the formulation of a statement of the objectives and concluding with the final step—the interpretation of results.

The sub-group evaluating the progress of the student in the basic sciences centred their discussion around the subject of anatomy and physiology. Several objectives of the course were outlined. Test items based on these objectives were prepared by each participant for presentation to the group. These items were then evaluated by the group at large. Means of integrating the basic sciences in the nursing arts and vice versa were discussed.

The group evaluating the student's progress in the nursing arts was convinced of the need for rather specific criteria in evaluating a nursing procedure. There was a variation of 15 points in the scores given by the group when they evaluated a simple demonstration. Emphasis was placed on the need for objective

evaluation based on principles. Criteria for the evaluation of the preclinical student on the hospital wards were discussed. The last day was spent on the construction of test items which could be used to measure certain of the objectives of the nursing arts course.

Those studying evaluation in the clinical area first outlined what they considered should be the level of attainment for the first, second, and third-year student and a few of the qualities we hoped would be developed for the student in each of the clinical divisions. The use of the anecdotal record was considered by the majority to be the only means of arriving at a true evaluation of the students' characteristics.

During the last hour the sub-groups met together to consider the appraisal of attitudes. This proved to be a most valuable experience for all.

In summary I can say for each member of the group that we have learned something of workshop technique. We did feel that we needed much more time to study student evaluation. Perhaps instead of continuing with workshops at the next biennial meeting, it would be possible to conduct them on a regional basis. The Hospital Association regional conferences have proven to be most satisfactory. I am certain that we in Alberta would welcome the opportunity to participate in workshops in which the four western provinces might combine.

The Nurse in Industry

DOROTHY M. PERCY

There were 40 registrants for this work conference, representing occupational health programs from heavy industry, light industry, business, hospitals, and universities; programs engaging from one to four nurses and serving in excess of 50,000 employees.

The registration was understandably low, since more than half the total number of industrial nurses in Canada are located in Ontario, with another large group in Quebec. The majority work alone and relief to attend a convention at this distance is a difficult obstacle, regardless of the interest the nurse or her management may feel. However, anything this group lacked in numbers was

well made up in enthusiasm and a desire for professional assistance and progress.

In the initial planning stages the core committee agreed that the keynote of this conference should be simplicity and practicability and that throughout the emphasis should be on the two-way flow—i.e., a consideration of industrial nursing in relation to the total nursing picture, with special emphasis on ways in which industrial nurses and the profession as a whole can contribute to each other's effectiveness in the broad community health program. An effort was made to maintain this theme in the sub-groups which were as follows:

1. The industrial nurse as an integral part of the community health team.
2. Employee health teaching and general counselling.
3. Techniques and procedures.
4. Employee and public relations.

It is significant that, although each sub-group discussed a different phase of the work of the industrial nurse, there was a remarkable degree of unanimity in the conclusions reached and that the preparation of the industrial nurse—which had been purposely omitted as a sub-topic—was discussed spontaneously by all sub-groups and practically identical conclusions were arrived at concerning it.

The findings of the sub-groups are summarized as follows:

1. The industrial nurse is an important member of the community health team and she should develop and maintain close working relationships with all health, welfare, and related groups. To achieve this, industrial nurses, individually and collectively, should explore all available resources and facilities.
2. Every contact with an employee is a potential opportunity for health teaching, on his own behalf or that of his family. Exploitation of this opportunity should complement the effectiveness of the general community health program rather than duplicate it.
3. The importance of applying non-directive counselling techniques to health, welfare, and personnel situations was stressed.
4. Standing orders are essential for the nurse in industry. Management should be advised to this effect.
5. There was developed an awareness of the importance of a planned public relations program for nurses in industry throughout Canada and the responsibility of each industrial nurse as a key person in instituting such a program. Two plans were formulated and the group decided they would like to try out these plans. The British Columbia group plan to meet again and give further study to the improvement of their techniques in public relations. It was recommended that all such plans should be integrated with those of provincial and national industrial nursing consultants.
6. All sub-groups agreed that the nurse in industry needs additional specialized

training. It was recommended that there should be either a special university course in industrial nursing, incorporating public health nursing principles, or that there should be industrial nurses' elective courses within the regular public health nursing course, covering such subjects as labor relations, first aid, counselling and guidance. Refresher courses and night classes should be fully utilized to maintain the competence of the industrial nurse. It was recommended that industrial nurses should be encouraged to meet for discussion of common problems and objectives but that this should be in addition to, not instead of, active participation in their district and provincial nursing associations.

This work conference unanimously agreed that the foregoing recommendations should be submitted to this meeting, but with the warning that they are the product of expediency rather than of slow and careful deliberation.

The members were conscious of a definite feeling of pressure which was aggravated by the necessity of attempting to reconcile two objectives simultaneously—namely, a comprehension of group dynamics and work on a problem with which they were primarily concerned.

As a result of this, the group recommends that:

1. If the C.N.A. considers repetition of work conferences at future biennial meetings, *all* participants, as well as chairmen, recorders, and observers, should receive preliminary intensive training for at least one day prior to the work conference and including a practical demonstration of the group process.
2. As an alternative, that consideration be given to the holding of institutes where experts, freed of preoccupation with the mechanics of work conference techniques, might be more readily available to stimulate group discussion.

A further need for caution was expressed by our group, with reference to the use to be made of the reaction forms. It was felt that it would be quite unsound to predicate any objective findings on the basis of these reports, submitted as they had to be, hurriedly, and without adequate understanding of the work conference method and the significance of the forms themselves.

The Nursing Team

LORNA M. HORWOOD

In presenting a report of our work conference, I have been asked particularly to express the appreciation of the teachers and consultants for the very valuable orientation to work conference method given us by Miss McDowell. It was a general feeling that we would have got into action more quickly if everyone had had such an orientation. It was felt that group leaders need to be especially well prepared.

The consultants felt that the participants might have come better prepared if they had received more encouragement and guidance well in advance of the meeting. Among other things, they might have been able to make use of the consultants to better advantage. The skill presented by the Vancouver nurses served as a very helpful on-the-spot introduction as the symposium developed. In spite of the feeling that in spending so much time on one problem we were missing much else that was important, interest was quite well sustained—of an enrolment of 54 nurses, 47 continued throughout. The interest in work conference method was sufficiently great that the members would like to suggest that the material on group dynamics, which Miss Nash forwarded from National Office, be sent out to the provinces with the hope that work conferences might be held at provincial and district levels.

There was a feeling that more getting together of the whole group to pool ideas would have been valuable. In this regard we were very happy that the consultant for *Le Travail d'Equipe en Nursing*—Mlle Giroux—was good enough to spare a few

minutes to tell us of the thinking within the French-speaking group.

We did to some extent meet our objective which was to acquaint nurses in hospital and other community health fields with the current trend toward teamwork in nursing in order to develop interest that may stimulate a desire for wider knowledge and understanding, promote the application of the principle of teamwork in the practical situation, and lead to experimentation in the various fields of nursing.

We did not go beyond this to specific recommendations regarding such live issues as reciprocity between provinces for the well-prepared auxiliary worker.

Discussion centred upon the professional nurse and the prepared auxiliary worker. The team concept was accepted by all as well as the need for much better preparation of the professional nursing staff at all levels before the advent of this newer member of the team. It was felt that in introducing the team to a hospital it would be well if one department could be selected for a controlled experiment. Functions of the practical nurse were discussed. The group which discussed the community aspect made such comments as: "Have gained a clearer picture of agencies and their combined uses to aid the patient."

While the general feeling was that the work conference has been very worthwhile, we are all agreed that the overlapping with other interesting programs is regrettable. It was the hope of our group that there would be more workshops but in a different setting and with more opportunity for orientation.

Staff Education Work Conference

HELEN M. CARPENTER

The enrolment consisted of 42 participants with representatives from both nursing education and nursing service in the hospital and public health fields and various gradations of experience from the student nurse to the senior administrator and educator.

At the opening meeting the plan of the work conference was discussed. The participants were assisted in understanding this method of working together by observing a demonstration of a group at work, undertaking to define their problems in staff

education. Following this introduction the registrants selected the group of their choice; their interests made possible the formation of three sub-groups varying in size from 13 to 16 members. The remainder of the first conference was spent in the discussion and definition of the problems each group wished to consider. Stating problems assisted participants to clarify their thinking and to recognize that like difficulties were experienced in widely varied services.

The sessions on Wednesday and Thursday were spent in the consideration of such questions as: How to initiate a staff education program; how to stimulate and maintain interest in staff education; how to use the group conference, interview, project; and other topics relating to this field of education. Opportunity was given each member to discuss her experiences and to share her problems. The pooling of knowledge was helpful and new approaches to common difficulties were uncovered as discussion progressed. Through working together it was generally felt that knowledge was extended and a more comprehensive understanding of staff education developed.

A work conference provides an opportunity

to share experience in the study of problems. It is an interesting educational device and one that seems helpful in assisting learning. Constructive suggestions submitted by the members to augment the value of this method were:

1. That participants be requested to submit their problems prior to the work conference and that they be compiled and distributed for study and consideration individually in order that the group could be ready to enter into discussion without delay.
2. That key participants in the work conference—that is, the consultants, leaders, secretaries, and observers—be those with knowledge of the subject under discussion, experience in leadership, and an understanding of work conference techniques.

Some felt that work conferences, as a part of the biennial meeting, caused conflict in that it was difficult to participate fully in other important aspects of the convention. It appeared to be the general opinion that such conferences might be organized and developed more satisfactorily on the provincial or local level.

Meeting the Total Needs of the Long-Term Patient

ALICE GAGE

In this work conference there were 47 registrants. The interests of the participants was such that it was decided to combine the areas of interest. There were two groups which studied:

1. The administrative aspects of a home care program and the rehabilitation of the long-term patient.
2. Nursing care and techniques in the care of the chronically ill and the affiliation of student nurses, either in an agency offering home care or in special hospitals for long-term patients.

Dr. Cherkasky's experience in this field and his ability to guide discussion proved a tremendous asset. I shall comment briefly on the results of group thinking in this conference. It was agreed that rehabilitation is the process by which the individual is enabled to obtain the fullest possible use of

his capabilities within his own limitations, thus deriving the greatest satisfaction in life.



Lee Holt, Vancouver

DR. MARTIN CHERKASKY

This can be achieved by enlisting the understanding and assistance of the patient's family and community. The following services, personnel, and physical needs are considered essential to an efficient rehabilitation program. However, if these services are not available, efforts should be made as soon as possible to provide them. Consultative service or transportation of the patient to diagnostic and treatment facilities should be made available.

The need for an educational program of personnel to recognize the needs is of prime importance. There should be a referral centre or clearing-house for information to provide direction and coordination of service whether rural or urban.

Personnel needs

1. Medical care with diagnostic and consultative services available.
2. Nursing service—institutional, visiting, auxiliary.
3. Evaluation of social and emotional needs—by social worker and medical-social worker, if possible.
4. Homemaker and housekeeper service.
5. Physiotherapy.
6. Occupational therapy.
7. Rehabilitation officer.
8. Vocational guidance with educational facilities.

Physical needs

1. Suitable housing.
2. Hospital: various types—acute, conva-

lescent, nursing custodial care, boarding homes.

3. Equipment and medication provided as necessary.
4. Transportation facilities.
5. Financial assistance to patient and family where necessary.
6. Employment service.
7. Recreational facilities.

The philosophy pervading this total program must be such as will recognize the patient as an individual, that it be suited to the patient's needs and so develop and maintain desirable attitudes of patient, staff, families, and general public. Thus this program may achieve its objective of meeting the total needs of the long-term patient. General conclusions reached by the groups were that:

1. The long-term patient should be segregated from the acute patient.
2. Teamwork is essential in meeting the physical, social, and emotional needs of the long-term patient and all existing facilities should be used to that end.
3. There should be an adequately supervised educational program in schools of nursing with the object of developing in the student nurse an awareness of the special needs of long-term patients. It was felt that this might be through affiliation with a centre where a well-planned program of total service for the long-term patient is in operation.

Student Nurse Work Conference

A. ISOBEL BLACK

Seventy-six student nurses representing 46 schools of nursing were divided into three groups to discuss: (a) the interpretation of the community's need for nurses to high school girls; (b) the purposes and responsibilities of a student organization within a school of nursing; (c) the objectives of professional organizations such as the provincial nurses' associations. Each group reported its findings separately following concentrated discussion.

Some of the difficulties encountered in student nurse recruitment programs and possible solutions to these problems developed from the discussions of the first group. One

caught the echo of many long-discussed propositions, including:

1. The value of dominion registration as a means of lowering some of the barriers.
2. The wide differences in schools of nursing. Some standardization is needed.
3. Means of holding the interest of student nurses in order to prevent them from terminating their training were suggested. These included:
 - (a) Active self-government.
 - (b) Suitable recreational and social activities.
 - (c) Students encouraged to take their

problems to their representative on the student council for action rather than attempting individual solutions.

(d) Student allowed to sit in on faculty and alumnae meetings to express student opinions.

(e) Better adjustment to residence life through provision of "Big Sisters," student counsellors, choice of roommate.

4. Financial problems deter many girls from entering training. Grants from governments, nursing associations, even the local student body would help.

The groups studying student government associations decided that an adequately functioning body has the following advantages:

1. It promotes unity among the students.
2. It provides a means for *professional* training by preparing a nurse to participate in alumnae, provincial, and national association activity.
3. It develops confidence and draws out potential leaders.
4. It improves social life and breaks down barriers between students.
5. It is the fund-raising body for the school.

The functions of a student government association were defined as:

1. To enforce residence regulations.
2. To act as a channel of communication between the student body and the faculty, thus creating a better understanding.
3. To promote social activities.
4. To donate to worthy causes on behalf of the students.
5. To send representatives to C.N.A. and provincial conventions.
6. To review and make constitutional amendments for the governing of the student body.

Since both the faculty members in a school and the students are interested, primarily, in the same thing—the patients' welfare—there should be a cooperative, harmonious relationship. This might be improved by:

1. The appointment of a board composed of graduates that would be advisory to the student association.
2. Focusing more attention on the honor system with fewer rules and regulations.
3. The inclusion of faculty members in the students' recreational and social activities.

4. Students to be notified regarding changes in ward procedures which affect them.

The importance of good school spirit was defined and discussed. The following ways of improving it were listed:

1. The provision of a sufficient variety of recreational and interest activities to meet the needs of all students.
2. Enthusiasm on the part of the seniors is a vital factor. Such enthusiasm is catching. The "adoption" of new students by the seniors was stressed again.
3. The choice of good leaders for the student government association was vitally important. The qualities desired in a leader were listed as: high ideals, intelligence, ability to inspire others, enthusiasm, broadmindedness, conscientiousness, independent thinker with respect for the opinions of others, ability to speak well.

The group concluded that improved school spirit would be reflected in a better functioning student government association. A greater sharing of responsibilities and better conducted meetings would increase student interest. It was felt that attendance at mass meetings should be compulsory. The president should fully explain the aims of their association and the constitution to each new class. Regular meeting dates, rather than occasional, sporadic sessions were advocated.

The third group started their discussion with the problem of why so few young graduates take an active part in their provincial nurses' associations. Does the fault lie with the nurse or with the association? Some suggestions for improving the students' background of information were proposed. Among these were:

1. That alumnae associations make provision for a greater degree of participation on the part of senior students, in the belief that their interest and co-operation should be fully aroused before they graduate. Students might be invited to attend each meeting, the dates being posted well in advance.
2. Courses in professional adjustments could be organized by the student participants themselves, in workshop fashion. An elementary course should be included at the end of the preliminary period with a more advanced study being made at the beginning of the senior year. In this way the students'

growth in interest in professional organizations and activities would parallel her other preparation.

The most promising means of stimulating professional development was felt to be through the organization of provincial student nurses' associations, sponsored by the provincial registered nurses' associations. The students were enthusiastically of the opinion that such associations are valuable. The aims of such bodies should be to improve the professional, social, and cultural background of student nurses.

It was recognized that objections to such student nurses' associations appear to exist in some provinces since only Manitoba and British Columbia have proceeded with organization. The chief factors seem to be the students' time involved and the barrier of distance between schools. The groups felt that these problems could be studied and overcome, and recommended that efforts should be made to organize provincial stu-

dent nurses' associations throughout Canada. The following proposals were made in this regard:

1. In each province, as many schools as possible get together to give their reports of this convention in order to stimulate interest within student bodies.
2. Where no provincial student nurses' association exists, an appeal be made to the provincial registered nurses' association to set up a Student Affairs Committee which would undertake the task of organizing the students' association as soon as possible.

It was inspiring to work with the students. All 76 of them, representing schools in seven provinces, studied, in a mature, professional manner, problems and activities of student nurses with a view to preparing themselves to function as strong, professional people and to strengthen their organization that they may serve better.

General Interest Sessions

JANET M. G. McLEAN-BELL

This was the first biennial meeting at which we have had General Interest Sessions. It was felt that the biennial convention afforded an excellent opportunity to bring the clinical fields and the nurse into closer contact to their mutual benefit.

These sessions were planned by a committee consisting of the national chairmen of the Institutional, Public Health, and Private Nursing committees, and several nurses representing various interest groups in nursing. Previous to our first meeting in February, all the provinces were contacted for suggestions as to the latest developments in nursing which would be suitable for display and demonstration purposes. So well did the sub-committees work together that it was necessary to hold only two general committee meetings.

It is impossible to describe in detail the many subjects covered. I will limit myself to a brief mention of a few and to the comments which I overheard during my tours. Well-illustrated posters, films, and pictures showed the latest in cancer treatment, psychiatric nursing, industrial nursing, home treatment of arthritis, good nutrition, repair

of hare-lip and cleft palate, burn therapy, rehabilitation of chronic illness, chest surgery, venereal diseases, and the administration of a central supply room. Exhibits of equipment showed the treatment of burns, eczema, the premature infant, the spastic child, cancer, and the post-operative patient.

One of the most frequent comments was: "Have you seen the neurological demonstration? You mustn't miss it—it's marvelous!" And it was a thrilling experience to see such precision, cooperation, and such a high level of nursing skill revealed during this demonstration. In fact there are rumors that in the near future a motion picture will be made of it. This will be eagerly sought by all teachers and supervisors. Credit is due our student nurses for the careful preparation and excellent delivery of their talks and demonstrations on poliomyelitis and burn therapy. We need have little fear of a lack of good instructors and supervisors in the future.

Many were the comments of appreciation for the opportunity to see the latest equipment being used in some hospitals and clinics such as the Stryker bed, the Swedish chair, the Simmons bed, the telebinocular and

audiometer machines, the Sweetland bed-warmer, the artificial kidney, and the Blanchard respirator to mention but a few of them.

The General Interest Sessions have proved a successful venture. If we are to call ourselves a professional body it behooves us to keep

abreast of the many rapid advances and changes in the art of nursing. These sessions provide one channel through which we may do so. I would recommend that this precedent be repeated and, if possible, the opportunity to attend the interest sessions be afforded to all nurses at the convention.

Demonstration School Administration Committee

At Sackville, in 1948, the committee reported the opening of the Demonstration School and the entrance of the first group of students in January of that year. Before reporting to the members of the Canadian Nurses' Association on action since then, it may be well to review very briefly the purposes of the demonstration.

The general purpose, of course, was to make a contribution to the solution of the health problem of Canada. In the actual carrying out of the experiment the most fundamental purpose was to demonstrate the type of organization which will permit the nursing school actually to be a school, in the sense that the word is used in other fields of education. By this is meant an organization in which the school controls the time of its students, rather than a service organization doing so to a large extent—in other words, financial and administrative independence of any hospital. Obviously this necessitates an income for the school.

Having obtained this income and this independence, the purpose then was to find the most economical method (in health, time, and money) by which an adequate bedside nurse could be prepared.

What progress toward these aims has been made in the intervening two years?

Our first class graduated in February, 1950. In September, 1948, a second class of 24 was admitted; of these 23 will graduate in October this year. In September, 1949, 24 more students were admitted. This September, 30 will be accepted, this number being about the maximum which our present clinical field will support. Nurses will be interested to know, however, that applications greatly exceed this number.

It has been asked how the program of

the school is to be evaluated. We need not argue now the question of the value of elaborate psychological tests, or whether good nursing can be measured mechanically; let it be admitted promptly that we are not using such tests at present. But there are some standards of comparison and measurement available to us. This school is visited by the same provincial adviser who visits other nursing schools; our students affiliate with others at several schools; they write the same registration examinations; they work with graduates in hospital wards and also with their instructors, who are of rather wide experience. The ultimate test is, of course, the graduate in action. Will people employ them? The answer in the case of our one group of graduates and of those just about to graduate is—yes, promptly and 100 per cent. It is in this employment that they are evaluated practically and finally. They and the School ask that they should be received in an open-minded way and judged on their merits; and this we think is being done.

Thus we may summarize results so far as follows: The freedom to plan the student's time for her learning advantage is realized more and more by staff and students to be invaluable and necessary, though this hardly needed proving. It would seem that the nurses being produced are *at least* able to hold their own in the field today; the hope is that they will continue to develop. A further result is an immense amount of interest in the demonstration, some of it from great distances and some about to result in similar experimentation.

What of the future? Writers in other countries have emphasized that this demonstration is unique and significant because

it is being carried out by the organized nursing profession of the country. Certain nurses have worked continuously with it but it was a unanimous resolution of the nurses present at a biennial meeting of the Canadian Nurses' Association which launched it. The demonstration still needs the participation of all our members. We assume that we all want it to go on without a break at the end of the original experimental period. It would appear that the only way it can do so is through public support and this requires public knowledge and demand. As members of the Canadian Nurses' Association we are at least obligated to understand and give a clear account of its policy; surely

many of us will want to add our personal conviction that, through the system of nursing education which we are sponsoring, we can both maintain the old standards of nursing and adjust them to new conditions.

We can never be sufficiently grateful to the Canadian Red Cross Society, the city of Windsor, and the Metropolitan Hospital, who have made the Metropolitan School possible. The best way to thank them is to see that it goes on without interruption. In this every member can help by telling other nurses, doctors, health officials, and the general public about it, and urging their support.

—NETTIE D. FIDLER

Annual Meeting in Saskatchewan

On May 27, 1950, preceding the annual meeting, 35 superintendents of nursing and instructors from the 10 hospitals conducting schools of nursing met in Saskatoon at the Bessborough Hotel. The meeting was organized by the Education Policy Committee, S.R.N.A., and was presided over by Miss Lucy Willis, education director at Saskatoon City Hospital.

Besides providing an opportunity for exchange of ideas and general discussion on problems of mutual interest, a number of important subjects were reviewed by individual instructors and then discussed by the group present.

- Efficiency reports
and graphs —Lucy Willis
- Pre-entrance tests
(English, spelling,
etc.) —Millie Turner
- Remedial English —Florence Bennee,
Instructor in English
Nutana Collegiate,
Saskatoon.
- Preliminary course
—content and
arrangement —Ethel James
- Examinations and
methods of con-
ducting them —Lola Wilson
- Bonuses and scat-
ter graphs —Gertrude James
- Laboratory teach-
ing —Lucy Rechenmacher

The 33rd annual convention of the Saskatchewan Registered Nurses' Association was held in the Bessborough Hotel, Saskatoon, May 29-30, 1950. All sessions were presided over by Miss Ethel James. Co-hostesses were the Prince Albert and Saskatoon chapters. Twenty-eight centres were represented and registration totalled 171. Special guests present were Miss Ida M. MacDonald, Consultant for Rural Nursing Education, New York State Education Department, and Miss Alma Walls, representative for J. B. Lippincott Co.

The reports of the chapters and of all committees indicated that the year had been a busy and eventful one.

The report of the registrar, Miss K. W. Ellis, dealt first with events on a national level. She spoke of the Nursing Care Study, Structure Study, plans for Evaluation of Schools of Nursing in Canada, and the proposed appointment of an educational secretary—all major concerns of the C.N.A. to be discussed at the biennial meeting in Vancouver. Turning her attention to developments on a provincial level, Miss Ellis dealt with the growth during the past year both within the organization and between voluntary and official bodies. She spoke of the increase in membership from 374 in 1930 to 2,021 in 1949. The work of the Provincial Government survey is progressing and it is hoped some valuable information will be forthcoming from this important study in the near future.

She paid tribute to the support of the Provincial Government in making financial help available for various projects, largely through the Federal Health Grants. Support has been given for: bursaries to assist nurses to take or continue post-graduate courses in teaching, supervision, or administration as well as in public health nursing; a workshop to teach Workshop Technique; a grant of \$2,000 now offered to schools of nursing for the purchase of approved teaching equipment, etc.; an annual grant for the support of the Nurse Placement Service; a plan to establish, on an experimental basis, affiliation for student nurses with *selected* hospitals in rural areas, under *carefully supervised* conditions and a similar affiliation with one or more public health units; and continued financial aid through the Dominion-Provincial Youth Training Plan for needy students in schools of nursing. Miss Ellis announced the decision of the Council to move the provincial offices to Regina, where they were formerly located. She said farewell to the association as registrar, for with the presentation of her report Miss Ellis formally announced her resignation as secretary-treasurer and registrar.

Miss Ellis' report as adviser to schools of nursing was filled with facts which are of vital interest to all. It indicated the need which still exists for an increase in teaching personnel and general duty nurses. It is of interest to note that, barring a few assistants, all instructors in schools of nursing have had some special preparation for teaching. Other special features mentioned in the report were: the experiments with the teaching program being undertaken in a few schools; the affiliation for student nurses in tuberculosis and psychiatry and the proposed affiliation in rural hospitals and health units. With few exceptions our schools have more applicants than they can accept and the majority of these have complete Grade XII standing.

Following the business session of the first morning, Miss Ida M. MacDonald delivered an address on "Centralization of Facilities as an Aid to Regional Planning for Schools of Nursing." This address was of special interest to all present inasmuch as affiliation for student nurses in selected rural hospitals in Saskatchewan is contemplated. Miss MacDonald stressed that the value of such affiliation lay in two facts: (1) nurses are so close to the patients that it is easier to remember that the patient is a person; and (2) the student gets to know the community and be-

comes acquainted with the problems of health and industry in the community.

A special luncheon meeting was held for chapter delegates. At this meeting some of the problems confronting chapters were discussed. Much valuable information concerning professional problems, chapter organization and programs was prepared to be carried back to the local chapters by their delegates.

A panel discussion on "The Graduate—What Does She Want Most" was led by Miss MacDonald. The four nurses participating in this were: Miss M. Ernschaw (Tisdale), Miss M. MacKenzie (Saskatoon), Mrs. M. Robertson (Saskatoon), and Mrs. E. Woods (Elrose). Ideas and facts on the economic question, job satisfaction, a program of orientation for *all* nurses in every field, community welcome for nurses, staff conferences, and the fact that "a nurse should have a chance to *nurse*" were all dealt with during the lively and interesting discussion.

Tuesday morning, the three standing committees held their meetings and discussed problems of particular interest to them, while the student delegates had a discussion on "Procedures at Public Meetings." This was under the chairmanship of Miss Sheila Leeper and was conducted by Mrs. A. L. Caldwell, B.Sc., Saskatoon. The three standing committees came together at 9:15 a.m. to hear Dr. D. M. Baltzan present a paper on "New Discoveries in Medicine." Dr. Baltzan vividly described the wonders of these new discoveries but pointed out the dangers that might follow the use of many of the new drugs unless administration is in the hands of those skilled in their use.

During the morning, time was devoted to the discussion of the proposed program of the C.N.A. in relation to the various new projects. In relation to the evaluation of schools of nursing, Sister Irene, superintendent of nurses, Holy Family Hospital, Prince Albert, presented a special paper which not only gave general information on the subject but answered a number of the questions nurses have been asking concerning this all-important matter.

A. C. Blackwood, Ph.D., assistant research biologist, National Research Council, Prairie Regional Laboratory, Saskatoon, addressed the meeting on Tuesday afternoon. His subject was "The Organization and Work of the National Research Council." He showed slides made at the Prairie Regional Laboratory to illustrate his talk.

On the last afternoon, on behalf of the S.R.N.A., Miss Ethel James presented Miss K. W. Ellis with a sterling silver dresser set as a small token of appreciation for her work as registrar of the association.

Of special interest at this annual meeting was the exhibit of original cartoons on "The Head Nurse," loaned by Miss Frances Reiter, assistant professor of nursing education, Teachers College.

The convention was not without its social events. A no-hostess luncheon was held on the last day of the meeting. A picnic on the lovely grounds of the Saskatoon Sanatorium on Monday afternoon provided a time of relaxation. Tours through the hospital were

arranged through the kindness of Miss Muriel Jarvis, superintendent of nurses, and her staff.

Ballots were sent to all members prior to the annual meeting. Those elected to office for the coming year were: Mrs. J. E. Porteous, president; Isabelle Langstaff, first vice-president; Sr. M. Tougas, second vice-president; Dorothy Code, councillor. Committee chairmen: Private Nursing, Mrs. Gertrude Anderson, Regina; Institutional Nursing, Agnes Campbell, Prince Albert; Public Health Nursing, Mary Edwards, Swift Current.

LOLA WILSON

Secretary-Treasurer and Registrar

Industrial Nurses Confer

(Concluded from page 814)

of the community in which she works and should not hesitate to use them. A film on cadmium poisoning, entitled "Capital Story," was shown to the group to illustrate his talk. Tuesday afternoon was spent in visiting several plants.

Wednesday morning was devoted to "Demonstrations and Displays." This session was under the capable direction of Miss J. Favreau, Quebec Hydro-Electric Commission. Books, folders, pamphlets, posters, and periodicals decorated the School. Several firms had booths and displayed fine exhibits of various medical supplies. Our attention was drawn to the requirements of an emergency bag, a new type of wheel-chair, and the latest in a sight-testing machine known as the Ortho-Rater. Several companies in Quebec have adopted the Ortho-Rater as a more accurate means of vision testing for placement and transfer of employees to jobs for which they are visually fit. Many nurses took the opportunity of having their eyes tested.

Mrs. Margaret Oulimar of the Victorian Order of Nurses, Montreal, gave a very interesting talk on "Opportunities in Home Visiting." She stated the industrial nurse should not assume the role of a truant officer. She should be a friend and counsellor, not only to the sick employee but to the whole family.

In the afternoon, Mrs. Genevieve Pembroke

spoke on "Public Relations." Her message was that we should welcome every opportunity to talk, particularly to groups within our companies. We should use simple English and speak so we can be heard. This was followed by a lively discussion period, which proved that everybody enjoyed the entire program. Nurses from a variety of industries exchanged ideas and discussed their problems. It was suggested that it would be of interest to the group to have short post-graduate refresher courses.

The evening session was presided over by Dr. R. P. Vivian, chairman of the Department of Health and Social Medicine, McGill University. He introduced Dr. K. C. Charron, chief, Industrial Health Division, Department of National Health and Welfare, who spoke on "Changing Concepts in Occupational Health"—a very interesting and informative talk.

On leaving the assembly hall, we were all invited downstairs to have refreshments. Tables had been attractively arranged with cut flowers. Groups congregated and exchanged greetings and ideas while they drank their coffee. A jolly atmosphere reigned and everybody, up until the last good-bye, seemed to enjoy themselves. A great many expressed hope that we would meet again as a unit in the near future.

VERA CLANCY

Nursing Supervisor

Northern Electric Co. Ltd.

Student Nurses

Cooperation in Health Services

DULCIE MELLISH

Average reading time — 8 min. 36 sec.

DURING OUR SENIOR YEAR we received a course of lectures in community health. To demonstrate the fact that the hospital is a community agency our last class was in the form of a panel. Our physician-in-chief has a very keen interest in the influence of the environment on the patient, both physiologically and psychologically. He asked to have his fourth-year medical students attend our panel. This combined class now is scheduled twice a year and takes the form of a panel on a family known to several agencies. All the agencies acquainted with this family present the aspects of the case as they have known them.

Presiding as chairman was Miss J. Whiteford, health instructor. Miss B. L. Pullen, superintendent of nurses, introduced the panel, consisting of Dr. J. D. Adamson, physician-in-chief; Miss I. McDiarmid, director, Social Service Department; Miss E. Graham, head nurse of a ward; Miss H. Setka, supervisor, Out-Patient Department; Miss D. Marshall, staff nurse, City Health Department; Miss E. Rose, staff nurse, Victorian Order of Nurses. Each of these presented a report of work done with the family. Miss M. Hart, director, School of Nursing Education, University of Manitoba, summarized the report.

The aims of the panel were outlined as:

1. To demonstrate the effective use of the hospital as a community health centre.
2. To understand the values to the

Miss Mellish wrote this account as a senior student nurse at the Winnipeg General Hospital.

patient of correlation of hospital and other community resources.

3. To understand the value of health teaching as it is integrated into the hospital care.

4. To illustrate the value of a knowledge of the patient's environment in providing effective patient care.

Dr. Adamson presented the medical aspects by emphasizing the patient as a unit in society, rather than merely a person with a disease. He stated that personality, intellect, temperament, emotions, education, environment, economic level, habits, occupation, recreation, and organic disease are all important to accurate diagnosis. In hospital, perhaps too frequently, the organic symptoms appear of greater importance.

Miss McDiarmid dealt with the social aspects of the Black family, consisting of father, mother, and four children—two boys and two girls. Mrs. Black, 41 years of age, has been taking epileptic seizures since she was 13. Her manner is very abrupt and rude at times. She worries about this and seems genuinely sorry but states that it is because she is distressed about the frequency of her seizures. The two girls are away from home and the two boys, who are still attending school, are at home with their mother.

In the past five years, the Winnipeg General Hospital has provided medical attention on different occasions for four members of the Black family. The aims of the ward nurses were presented by Miss Graham as being:

1. To meet the family's need for bedside care.
2. To assist the family to improve their standard of health.

3. To help the individual make a better adjustment in his post-hospital care.

Thereby we see where every nurse has a responsibility for the health of the public.

On different occasions Mr. Black was admitted to hospital where he was given adequate medical and nursing care for eyestrain, and two serious accidents which made it necessary to amputate part of one finger. Poor lighting and poor working conditions were suggested as possible causes. In reviewing the care given Mr. Black, Miss Graham thought that periodic physical examination should have been stressed and that he could have been referred to the Department of Industrial Hygiene. This would have assisted him to make a better adjustment.

The first contact with the principal person—Mrs. Black—was in the casualty ward in May, 1945. She and her baby, Robert, had burns sustained from boiling water, thought to have been caused during one of the mother's epileptic seizures. In view of their untidy appearance, their unsatisfactory dressings, and because there was no one at home to care for the baby, they were admitted to hospital.

Miss Graham was able to show our group where patient teaching in hospital is essential to an epileptic in helping her understand her condition and her limitations. The nutritionist was consulted and Mrs. Black was given a special diet. She was referred for dental care and was given exit prescriptions for vitamins and stilbestrol.

The students were shown how the emergency service in a hospital can assist patients by detecting their needs for education and trained nursing care. On her discharge the mother was referred to Social Service who in turn contacted the Victorian Order of Nurses for the supervision and care of the burns in the home.

Miss Rose then illustrated how the V.O.N. can assist the patient by giving post-hospital care. Several visits were made to do burn dressings as well as to help the mother to adjust to her epileptic condition.

Miss Setka, in evaluating the aspects of the Out-Patient Department, stated their aims:

1. To render efficient medical diagnosis to the ambulatory patient on small or no income.

2. To promote adequate medical and nursing education and supervision to the patient, thus enabling him to remain or become rehabilitated. Casualty, being primarily for emergency care, is often a stepping-stone to Out-Patient Department for the patient with this income.

The members of the Black family have been seen in casualty, surgery, medicine, prenatal, dermatology, and pediatric clinic. Mrs. Black's visits were very irregular. Perhaps, through closer working relationship with Social Service and other community agencies, this problem would have been solved.

Miss Marshall illustrated how the public health nurse met the needs of the Black family. The first contact the public health nurse made was five years before when she supervised the mother and new baby on their return from hospital. Other visits were made to the home because of the frequent absence of the youngest girl from school and because of Mrs. Black's epileptic seizures. Referrals were made to the Children's Aid Society due to apparent neglect of the children during the mother's absence in hospital. During their visits the nurses gained Mrs. Black's friendship and confidence, an essential feature in public health nursing. In so doing they helped Mrs. Black and family make better adjustments.

Mrs. Black has a genuine feeling of affection for her children. Within her capacity, she is interested in improving her home for the family and she shows appreciation for what is done for her.

Epilepsy, unlike most long-term illnesses, is sometimes regarded by the patient as not being socially accepted. It is important, therefore, for doctors and nurses to be aware of the mental or emotional aspects of such people and to display sympathy and understanding to gain more cooperation from the patient



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and to help her to live with her disease.

This panel has shown how the many agencies in the community, including the Winnipeg General Hospital, mesh their services and how the health and social agencies of our city

and province work together to meet more effectively the needs of a family. For instance, they help keep homes together, assist persons handicapped with epilepsy to meet their responsibilities, and help children to have a more normal development.

A Break with the Past

The Metropolitan Life Insurance Company recently announced to the company's field force, to local public health nursing agencies, and to its own visiting nurse staff the discontinuance of the company's home visiting nursing service to policy-holders in the United States and Canada, effective not later than January 1, 1953. The marked improvement in health conditions and the increased hospitalization for acute illness and maternity care—the types of conditions for which the Metropolitan's nursing service was established in 1909—are important factors which have led to the company's decision.

The company has been closely identified with public health nursing since the beginning of its nursing service for policy-holders. Although it has recognized the value of all types of public health nursing, the company's service has consisted almost exclusively of home visiting in acute illness and limited prenatal and postnatal home care. The improvement which has taken place in disease and accident prevention, as well as in treatment, has diminished the need for this service. For the past two decades the requests from policy-holders for service have declined steadily. During this time physicians have made increasing use of the hospital rather than the home for diagnosis and treatment of acute illness and serious accidents, as well

as for maternity care. Meanwhile, visiting nurse associations have multiplied in number and broadened their programs to include services to industries, schools, care of chronic illness, etc. Local health department participation in nursing has grown and voluntary sickness insurance programs have begun to include nursing benefits. All of these factors have contributed to lessening the requests for the company's nursing service to a point where now only a small percentage of all policy-holders use the service.

President Leroy A. Lincoln emphasized that the company, through its Health and Welfare Division, is continuing its traditional interest and activity in disease and accident prevention and health promotion. It intends, as in the past, to adapt its program to current conditions, discontinuing those in which the purpose seems to be accomplished and turning its attention to new problems which require solution. Mr. Lincoln's announcement paid warm tribute to the splendid service rendered to the company's policy-holders by its salaried nursing staff as well as those official and voluntary nursing organizations which have participated in its bedside nursing program.

N. L. BURNETTE, D.Sc.S.
*Assistant Vice-President
Health and Welfare*

Sugar Substitute

A new heat-stable, non-caloric synthetic sweetening agent, which is reported to be highly beneficial in restricted and low-calorie diets such as those followed by thousands of diabetics and reducers in this country, is

now being manufactured in Canada by Abbott Laboratories Ltd.

Known as SUCARYL Sodium (cyclamate sodium, Abbott), it contains 125 mg. of sodium cyclohexyl sulfamate, 269 mg. of



Player's
NAVY CUT

Mild or Medium
PLAIN and CORK TIP

PREVENT FIRES
ENJOY IT Then BE SURE IT'S OUT

Player's Please always

sodium bicarbonate, and 240 mg. of tartaric acid.

The new sweetening agent has the ability to sweeten foods without adding forbidden calories or carbohydrates to the diet. Previously saccharin was the only non-caloric sweetener available. It is decomposed by heat which causes it to lose its sweetness. Saccharin is also frequently described as having a bitter after-taste when used in drinks and uncooked foods. Sucaryl has no bitter after-taste when used in ordinary proportions. Being heat-stable, it can be used in cooking, baking, or canning and performs its sweetening function even in boiling solutions.

With the development of Sucaryl it is now possible for diabetics and reducing patients to include a wide variety of foods in their diets which were formerly restricted because of sugar content and not possible with saccharin because of its instability. It is stated that Sucaryl will also simplify the problem of having to prepare a special diet for one

person because food and drinks sweetened with Sucaryl are equally palatable to all members of the family.

Sucaryl will be supplied in tablet form, with each eighth-gram tablet equivalent in sweetening power to one teaspoonful of sugar. The tablets are effervescent to reduce dissolving time to a matter of seconds in warm solutions. Each tablet is grooved for easy separation to suit individual tastes. The tablets will be packaged in handy bottles of 100 tablets, as well as bottles of 1,000, available to the public at drug stores only.

Although Sucaryl will be prescribed or recommended by physicians it will also be available without prescriptions. However, because it will be used continually by people in all states of health a precautionary limit of eight tablets per day has been imposed for each user. And because sodium salts are relatively slowly eliminated, it is advised that patients suffering from severe kidney ailments take Sucaryl in moderate amounts and only under doctor's supervision.

(ammonia dermatitis)

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Tongue Important Disease Indicator

Years ago a doctor's observation and study of a patient's tongue were an important part of nearly every physical examination.

"Let me see your tongue," the old-time physician would ask his patient, and from its appearance and color he could usually make an accurate diagnosis. He was quick to recognize the strawberry tongue of scarlet fever, the shriveled tongue of dysentery, and the brown, dry tongue of typhoid fever.

"Newer diagnostic methods and increased laboratory facilities have supplanted to some extent such detailed observation," says Dr. Russell A. Sage of Indianapolis, but he adds that, despite all the scientific advancements, the modern physician can still rely on the tongue as an important indicator of many diseases.

Writing in the *Archives of Otolaryngology*, published by the American Medical Association, Dr. Sage tells how nature has adapted the tongues of animals to meet individual requirements. In the muskellunge, for example, toothlike appendages are present which enable the big fish to hold his prey while he turns and scales it and in the cow the "non-skid" surface of the tongue enables the animal to grasp its grassy food better.

In man, sores of the tongue are commonly found on the surface or covering tissue which transmits sensations to the brain. Changes of temperature, touch sensations, and the ability to perceive the four basic flavors—salt, sour, bitter, and sweet—are the primary functions of the tongue-covering membrane.

"Generalized nervous disorders may be shown by certain misbehaviors of the tongue," Dr. Sage says, citing as examples the tremors seen in hyperthyroidism, the clumsiness of the tongue in decreased thyroid function, and its "purposeless movements" in chorea or St. Vitus' dance.

In anemia, where the number of red blood cells or the amount of hemoglobin in the blood is reduced below normal, the tongue becomes pale.

A slick tongue, Dr. Sage says, usually means vitamin deficiency.

A coated tongue often has little to do with the state of a person's digestive system. "It may be a local condition due to lack of oral cleanliness," the author writes.

Edema or swelling of the tongue is due to

infection or allergy. It often occurs in persons who have eaten fish, walnuts, or chocolate and it may result from bites and stings of insects or other injury.

An inflamed tongue might be caused by irritation from a jagged tooth or by an infection of the taste buds, while a burning tongue is usually associated with various forms of anemia and vitamin deficiencies. A poor fitting denture or excessive smoking may also cause a burning sensation of the tongue.

Vitamin deficiencies, due to lack of riboflavin and to lack of nicotinic acid (the cause of pellagra), bring on an inflammation of the tongue.

A "geographic tongue," in which the surface is marked by long, deep furrows instead of being smooth, is a common condition. Grayish thickened patches on the surface are noticed. The condition is "relatively harmless but causes a great deal of worry in the mind of the patient," Dr. Sage says.

Ulcers of the tongue occur from infection and chronic irritation and one of the most distressing tongue afflictions is the common canker sore. There are several types and it is believed that indigestion, infected tonsils, adenoids, and uncleanness of the mouth and teeth are contributing causes to this unpleasant and painful mouth condition.

Dr. Sage says one type of canker sore occurs periodically in otherwise healthy adults and is probably due to an idiosyncrasy for some food, such as fish or walnuts. Until the offending food is discovered, the only treatment of value is light cauterization. "This," writes Dr. Sage, "sears the endings of the sensory nerves and enables the patient to eat with comfort."

Abscess of the tongue may result from wounds, especially puncture wounds or infections deep in the tissues. Recovery is quite rapid after the abscess has been opened.

Dr. Sage says that pathologic conditions of the tongue may be classified as tissue growth and destruction, infections, cancers and tumors, abnormalities present at birth, and disturbances due to mechanical causes.

—Health News

The Canadian Arthritis and Rheumatism Society has announced details of the fellowship program that it is sponsoring for medical post-graduate study of rheumatic diseases. Two hospitals in Canada—Sunnybrook Vet-



Beauty Counselors AND THE CANADIAN NURSE

GIFTS OF LOVELINESS

(No. 5 of a series)

For the past several months we have been chatting about Beauty Counselor products . . . the research which gives them their enviable position among Canada's leading cosmetics . . . the men and women behind the products . . . and the Counselors who are proud to represent them.

This column will deal with something a little different . . . an extra service offered Canadian women in time for Christmas giving.

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Adeline E. Johnston, M.A.

President

Beauty Counselors of Canada, Limited
Windsor, Ontario

*New Editions of Macmillan
Nursing Texts*

**NURSING CARE OF THE
SURGICAL PATIENT**

By J. P. West, M.D. Attending Surgeon, St. Luke's Hospital, New York City; Manelva Keller, R.N. and Elizabeth Harmon, R.N., Instructor in Surgical Nursing, New York City Hospital. 500 pages, 1950. Price \$4.00.

Previously titled **TEXTBOOK OF SURGICAL NURSING**, the fifth edition of this popular book has been completely rewritten to include modern practices in the field of surgical nursing. The *total* nursing care of the patient is emphasized throughout.

**NUTRITION AND DIET
THERAPY**

By Fairfax T. Proudfit, University of Tennessee School of Nursing, and Corinne H. Robinson, formerly at Columbia University School of Nursing. 950 pages, 1950. Price \$4.00.

The new tenth edition brings entirely up to date this well established text in dietetics. Much new material and many new illustrations have been added.

**THE MACMILLAN COMPANY
OF CANADA LIMITED**
70 BOND STREET TORONTO 2, ONTARIO

erans Hospital, Toronto, and Royal Victoria Hospital, Montreal—have indicated their willingness to accept suitably qualified doctors for this important work. Other hospitals in the United States and Britain are prepared to provide similar opportunities for fellows.

Nursing in Norway

As in other countries, there has been an almost catastrophic shortage of nurses. Hospitals have had to call on untrained nursing personnel, to whom they give some sort of instruction, although there are no schools for training so-called practical nurses nor are these schools being planned. At the International Conference in Stockholm, the Northern countries, especially Denmark and Norway, kept aloof from the idea of training practical nurses. Assistants in hospitals in Norway are regarded as temporary aids until nurses in sufficient numbers can be recruited to meet the demand. The situation already shows considerable improvement. . . Many feel that a small country with a population of approximately 3,000,000 people should not attempt to educate two different types of nurses. This, for one thing, does not seem quite fair to the young people themselves, since many would choose the shorter period of training and the less expensive education.

—*Information Bulletin for Red Cross Nurses*

School Children Health Care

Basic principles for provision of health care for school-age children have been defined for the first time on a world-wide basis by a group of medical officers, pediatricians, school physicians, health educators, and nurses called together by the World Health Organization.

The expert committee on school health services, which met at Geneva, August 5-12, emphasized the need for school services to be organized as "team projects" involving parents, the community, professional groups, social agencies, and others interested in child welfare. Moreover, the committee pointed out, school health services should be a direct continuation of preschool services.

They stressed the belief that schools in all



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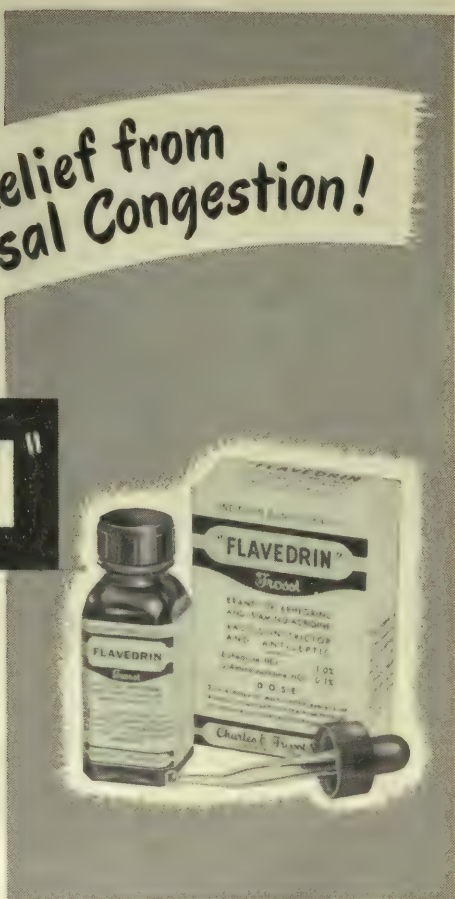
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MONTREAL

CANADA

VOLUME 46
NUMBER 11
MONTREAL
NOVEMBER
1950



THE CANADIAN NURSE

DETACHMENT OF
THE RETINA
Jean McCulloch

THE MENOPAUSE
F. Gibson, M.D., C.M.



OUR NATIONAL
LIBRARY, OTTAWA

Photo by E. Gertrude Ferguson, R.N.



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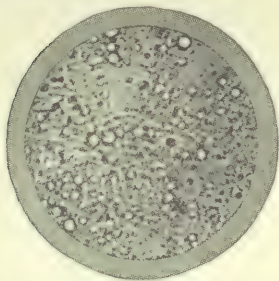
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septic (hydroxy quinoline) added. As the water phase evaporates, a discontinuous film (see photomicrograph) is left on the infant's skin.

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BABY
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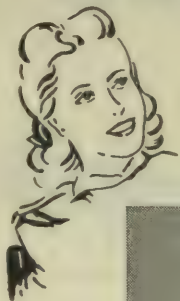
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Keep "217" Tablets handy for fast protection. Three ingredients acting synergistically provide a strong analgesic and antipyretic effect that quickly overcomes headaches, neuralgia, rheumatic and arthritic pains and colds. The handy tube of 12 tablets fits conveniently in pocket or purse; economy sizes of 40 and 100 are ideal for home use.



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MONTREAL CANADA

The Canadian Nurse

VOLUME 46

NUMBER 11

NOVEMBER, 1950

NEW PRODUCTS.....	862
DEVELOPMENTS IN TORONTO	869
EYE EMERGENCIES	<i>E. Wolstein, M.D.</i> 870
DETACHMENT OF THE RETINA.....	<i>J. McCulloch</i> 872
THE CHEMOTHERAPY OF CANCER.....	<i>P. Taylor, Ph.D.</i> 875
THE MENOPAUSE.....	<i>F. Gibson, M.D., C.M.</i> 879
BUILDING MATURITY	<i>C. M. Schram</i> 881
NAVAL MEDICINE	<i>W. M. Little, M.D.</i> 883
HINTS ON GENERAL FIRST AID.....	<i>O. Hoffman, M.D.</i> 886
LYLE CREFLMAN WRITES.....	888
WE WERE SKEPTICS.....	<i>Sr. P. Fortier and M. O'Hara</i> 891
THE TEACHER-NURSE TEAM.....	<i>D. B. Marshall</i> 895
SERVICE SOCIAL À L'ECOLE DES INFIRMIÈRES.....	<i>G. Lamarre</i> 899
NURSING PROFILES.....	902
TRENDS IN NURSING.....	907
ORIENTATION ET TENDANCES EN NURSING.....	908
CORPUS LUTEAL HEMORRHAGE—SURGERY AND NURSING CARE	<i>C. F. Harvie</i> 910
BOOK REVIEWS.....	915
NEWS NOTES.....	926
OFFICIAL DIRECTORY.....	936

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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**Current Clinical
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REPORT No. 6

EFFECT OF
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 IN THE
 DIETS OF
 PREMATURELY
 BORN BABIES

In this research, the effect of meat on the hemoglobin concentration, erythrocyte count, weight gains, and serum protein values of prematurely born infants is being investigated. Other factors that develop in the course of the study will be analyzed as to their value to infant nutrition.

This study is part of an extensive clinical research program now being conducted through grants-in-aid made by Swift's.

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To help establish nutritionally sound eating habits, Swift offers a complete variety—in either Strained or Junior form—beef, lamb, pork, veal, liver, heart. All six, 100% meat, are trimmed to reduce fat content to a minimum. All are carefully cooked, ready to serve.

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All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.



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Between Ourselves

A *pot-pourri* of articles this month. You will find that **Dr. Phyllis Taylor's** article presents many interesting developments on the treatment of **cancer**. It takes a tremendous amount of research to uncover all of this material. We are grateful for the permission to reprint it for your information. Pseudo-scientific periodicals occasionally give such prominence to new discoveries in the field of cancer research that it is important that we should have authentic facts with which to meet the queries put to us by our patients and their families.

* * *

Dr. E. Wolstein presented his material on **eye emergencies** at a refresher course for industrial nurses in Ottawa. As we read it we felt there was much useful information there for all public health nurses. **Jean McCulloch's** excellent paper on detachment of the retina will refresh your memory on this delicate eye operation.

* * *

So many women, nurses included, have exaggerated ideas and dread of the approach of the **climacteric** that the light which **Dr. F. Gibson** sheds on this normal function should serve to dispel much of the ignorance. Few people get particularly agitated over the onset of adolescence when the hormones first begin to function. True, there are occasional instances of glandular upsets which require therapy. By and large, however, there is no interference with activity. How different it is at the other end of the period! Perhaps it is largely attributable to our innate revolt against the approach of old age. Let us follow **Dr. Gibson's** advice and be sensible about it when our turn comes.

* * *

We have commented previously on this page regarding the assistance given by nurses in all parts of Canada in the preparation of **book reviews**. Recently one of the nurses who had made such a review wrote us a charming letter when she submitted her contribution. We want to share part of her letter with you. Perhaps it will serve as a stimulus to some of you to send in your names as potential reviewers. Here it is:

"The task is finally accomplished and I have enjoyed it. I never realized how much

I was missing by what I formerly called 'reading.' . . . May I do another review at some time? . . . Thank you for opening my eyes to a new adventure in reading."

Would you like to share in this form of "adventure"? Simply write to us telling us the particular aspect of nursing with which you are most familiar and we will add your name to our list. Obviously it would be unfair to ask you to make a critical evaluation of a book dealing with psychiatric nursing, for example, when you know much more about obstetrics and gynecology. That is precisely why we need the assistance of so many of you. Won't you send us your name? The lure may be that the book you review becomes your personal property.

* * *

For several months now we have been privileged to carry the intimate, personal story of Miss Creelman's activities with the World Health Organization on her page entitled **Lyle Creelman Writes**. When the copy for this month's issue arrived we found that Miss Creelman had appended a little note in which she said that "fan mail" was beginning to arrive. We feel sure that there are many of you who would like to add your appreciation of her interesting glimpses of life and work in distant places. If you send your letters in care of the *Journal* we shall gladly forward them. If you prefer to write to her directly, her address is *World Health Organization, Palais des Nations, Geneva, Switzerland*. Please mark your letters "Private Mail." Incidentally, postage to Switzerland is five cents for first class letters.

* * *

Instructors of nursing who are searching for **films and filmstrips** to use in their teaching will be interested in and rewarded by a scanning of the list that is contained in the September, 1950, issue of *Canada's Health & Welfare*. These visual aids are related to topics that usually are included in the courses on community health and social needs and will supplement the regular instruction, especially when a public health nurse is not available. Such topics are included in the extensive list as: Maternity and Child Health, Mental Health, Nutrition, Venereal Disease Control. Titles of available printed material on each topic are also included.

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New Products

Edited by PROFESSOR F. N. HUGHES

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Indications—Acute infections due to wide range of bacteria, rickettsial, and certain viral and protozoan groups; hence used in acute infections due to gram positive or gram negative bacteria, including gonorrhea, pneumonia, brucellosis, urinary infections, spirochetal infections, lymphogranulome venereum, primary atypical pneumonia, herpes zoster, typhus, amebiasis.

Administration—Orally, as prescribed by the physician and varying in individual cases.

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Manufacturer—Parke, Davis & Co. Ltd., Walkerville, Ont.

Description—Chloromycetin (chloramphenicol)—a crystalline antibiotic having specific therapeutic activity against a wide variety of pathogenic organisms, in capsules containing 50 mg.

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Administration—Orally, as prescribed by the physician.

HEXATHIDE

Manufacturer—Allen & Hanbury's Co. Ltd., Toronto.

Description—Each cc. of solution for injection contains 20 mg. hexathide (hexamethonium iodide)—a ganglion blocking agent.

Indications—Peptic ulcer, peripheral vascular disease, and hypertension.

Administration—For hypertension and peripheral vascular disease—1.5 to 2 cc. intravenously with patient in the supine position. For peptic ulcer 5 cc. of solution intramuscularly with patient in the supine position. Should always be administered to patients in supine position as the hypotension produced causes faintness, particularly when the patient assumes prone position. Symptoms can be relieved by placing patient on a couch and lowering head below the level of the trunk. Patients should be kept under observation for one hour after administration of hexathide.

ISOPRENALINE SULPHATE

Manufacturer—Allen & Hanbury's Co. Ltd., Toronto.

Description—Isopropyl nor-epinephrine—tablets and spray solution. Each tablet contains 10 mg. Spray solution contains 1%.

Indications—Bronchial asthma, in place of epinephrine or, in severe cases, supplementary to epinephrine to reduce number of injections. Stated to be superior to ephedrine and may be used routinely by chronic asthmatics, especially those sensitive to cardiovascular effects of ephedrine or epinephrine.

Administration—Tablets, sublingually. Average dose 10 to 30 mg. three times daily; 1 cc. of solution can be sprayed into the mouth to avert an impending attack, deep inhalations of breath by patient being synchronized with each compression of atomizer bulb.



HANDS LOOK LOVELIER IN 24 HRS. ...OR YOUR MONEY BACK!

**Red, rough chapped hands are a
real "occupational hazard"
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—M.L.I.C. Statistical Bulletin

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¹Kraemer, M.: Postgrad. Med. 2:431 (Dec.) 1947.

²Kraemer, M., and Siegel, L.H.: Arch. Surg. 56:318 (March) 1948.

³Martin, G. J., and Wilkinson, J.: Gastroenterology 6:315 (Apr.) 1946.



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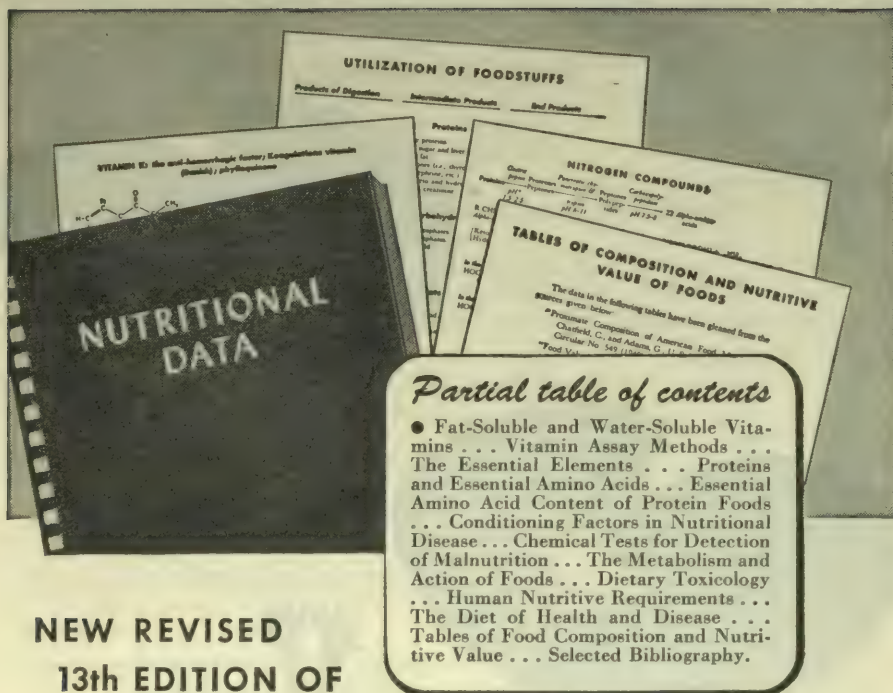
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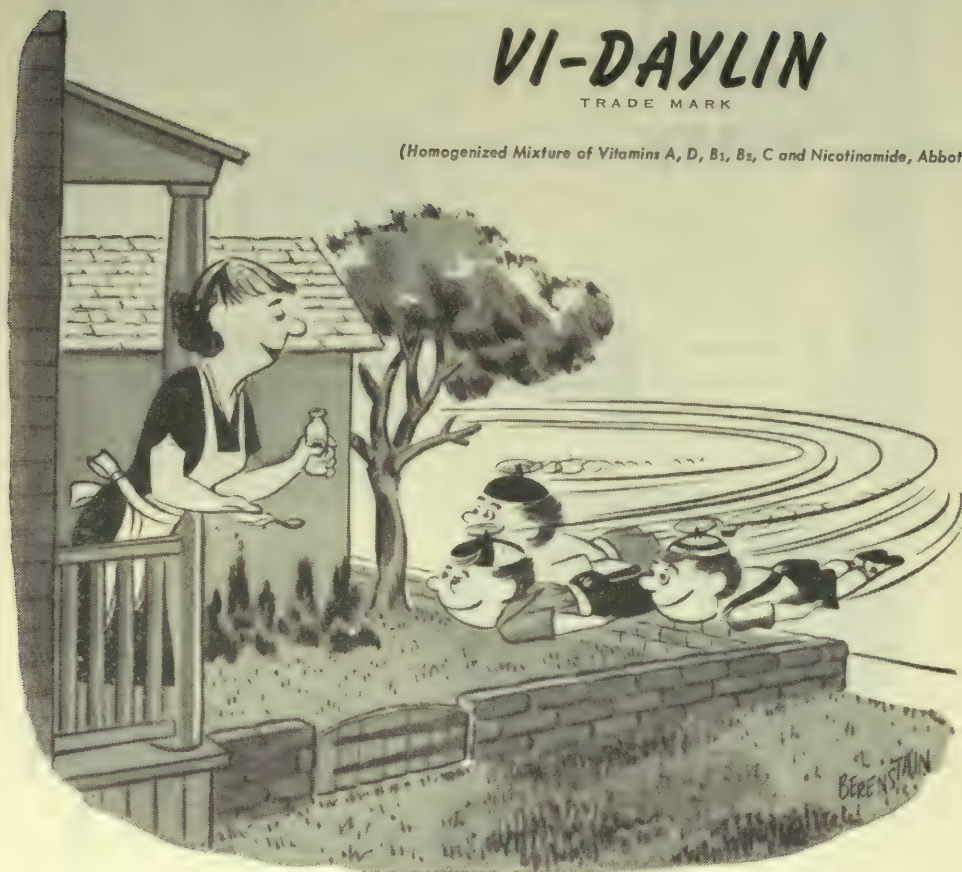


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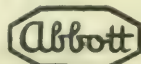
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The

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MONTREAL, NOVEMBER, 1950

Developments in Toronto

Average reading time — 3 min. 36 sec.

NEARLY FIVE YEARS AGO, Miss Marjorie Jenkins of Nova Scotia, in a guest editorial in our *Journal*, put into words some of the questions and regrets that nurses everywhere felt in regard to our present pattern of nursing education. Miss Jenkins said:

The hospital school of nursing seems to be the forgotten school in the field of education. Abiding under the shadow of the hospital, for the benefit of which it exists, it remains alone, unaided, outside the pale of public consideration. It proceeds largely untouched by modern educational enlightenment. Its growth and expansion are hindered by the character of its existence, being controlled by the hospital, whose main interest is its service to its patients. Financially dependent upon the hospital—for it has no budget of its own—it struggles along, crippled and unfree, deep in the mire of hopeless frustration.

A pretty gloomy, depressing and pessimistic picture, to be sure! Though there are many fine and progressive schools of nursing in Canada, at the time in 1946 when Miss Jenkins' editorial was published there did not seem to be much prospect of reno-

vating the general pattern. Three vital criticisms were noted in that single paragraph—lack of adaptation to modern educational trends, control vested in the sponsoring hospital, financial dependence.

The first gleam of light on this dark scene came through the inspiration, interest, and persuasion of Miss Kathleen Russell. Acting on her proposal, the Canadian Red Cross Society met one of the problems by providing for the financial independence, for a definite period of years, of a demonstration school. It was duly arranged that this school—the Metropolitan School of Nursing, Windsor, Ont.—should be free from the pressure of total responsibility for the provision of nursing care. Thus planned and developed, the school has been able to provide a well-integrated, broad program of nursing education for a representative group of students in a shorter period of time than such a course customarily takes. Already the second class has graduated and the young women are participating actively in nursing duties in various communities.

Within recent weeks, another de-

velopment along somewhat similar lines has been announced. A grant of \$100,000 from The Atkinson Charitable Foundation has made possible an immediate start on another two-year course in nursing at the Toronto Western Hospital. The aims of the program, which opened the middle of September with an initial enrolment of 80 students, are:

1. To accelerate the supply of nurses, which has fallen so far behind the need that the situation long has been critical.

2. To establish a streamlined curriculum, closely coordinating classroom and clinical studies, and designed to improve on present methods.

Mr. A. J. Swanson, superintendent of the hospital, stated that, in addition to the grant from the Foundation, assistance is being provided by the Ontario Department of Health, the federal Department of National Health and Welfare, and Toronto Western Hospital. A new educational

building will be constructed immediately to provide the necessary classroom and laboratory space.

Under the present plan, the students will receive their complete grounding in nursing education in two years. They will then be required to serve an extra year as nurse internes, either in their own hospital or in one to be designated. They will be paid a salary during this year of internship. A future development, when the new course has been proven, might be the abandonment of the third year. The course will be guided by Miss Gladys Sharpe, director of nursing, and Miss Blanche McPhedran, associate director of nurse education, assisted by a group of highly qualified specialists for teaching purposes.

Thus, the morbid state of nursing education which Miss Jenkins decried is yielding place to active programs which promise to revolutionize nursing education in Canada.

Eye Emergencies

E. WOLSTEIN, M.D.

Average reading time — 5 min. 36 sec.

THE MOST COMMON eye emergency is that of a foreign body. The history is sudden pain in the eye and the patient usually feels the pain until the foreign body is removed. In examining the eye ask the patient to point with his finger to where the pain is greatest. In most cases that is where the foreign body will be found. Focus a good light on the affected eye and tell the patient to keep both eyes open. If he can do so it requires less manipulation on the part of the examiner. Have the patient move his eyes to both sides, then up, pull down the lower eyelid and a floating foreign body is often found. This is withdrawn with a

moistened cotton wool applicator. If no foreign matter is seen evert the upper lid. In this manoeuvre the patient must look down while the upper lid is rolled back, either with one's finger or over a match held against the skin of the lid. If no foreign body is visible, and the pain persists, the patient should be referred to an ophthalmologist, as should the patient whose foreign body cannot be removed in the manner described.

When the history suggests an intraocular foreign body the affected iris will be seen projecting forward much more than in the other eye and the pupil is often distorted. Do not test the ocular tension for fear of reopening the original wound and losing aqueous or vitreous fluid. If

Dr. Wolstein is an eye specialist in Ottawa, Ont.

in doubt, pad the eye and refer to an ophthalmologist at once.

A common eye injury is a corneal abrasion incurred by a finger scratch, a piece of wood, or a large foreign body that abrades the surface but does not embed. After ensuring that no foreign body is present, instil one drop of 2% fluorescein, wash out with normal saline, then examine the cornea. An abrasion will show up as a bright green patch. If it is small, instil 30% sodium sulfacetamide and pad the eye till the following day. If pain or the abrasion persists refer to an ophthalmologist. There is danger of infection with its sequelae of corneal scarring. A clean, superficial corneal abrasion heals quickly and without scarring.

Chemical injuries to an eye require immediate first aid treatment. Whether the chemical be alkali or acid irrigate the eye with *large amounts of fluid*—water, normal saline, boracic solution, or whatever bland fluid is at hand. Irrigate for five minutes, wait several minutes and irrigate again for five minutes. If the chemical is lime small particles may be seen on the surface of the conjunctiva. Instil one drop of 1/2% pontocaine and pick these out with fine forceps. Repeat the irrigation a few more times and refer to an ophthalmologist. The complications of chemical injuries to an eye are scars and their contraction.

The most common eye injuries due to exposure to radiant energy are the flash burns seen in welders and as the result of sudden sparking in power plants. The resultant pain may ensue immediately or be delayed up to twelve hours. The pain is due to minute corneal abrasions. These heal quickly after instilling castor oil and padding the eyes. It is not recommended that anesthetic drops be instilled in case further corneal damage results.

Lacerations in the vicinity of the eye must be carefully sutured, using fine black silk suture and fine needles to avoid scar contraction and distortion of the eyelids. When the laceration includes the margin of the eyelid

it is best to refer the patient, as the lid must be sutured in layers.

The well-known black eye is due to hemorrhage in, or extravasation of, blood into the skin of the eyelids. If painful, a fracture of the orbital margin is a possibility. There is no effective therapy that will reduce the swelling and color of the condition in short order.

The differentiation between a sty and an acute chalazion is of interest. A sty is an infection of a hair follicle and it points at the margin of the eyelid where the hairs emerge. An infected chalazion, or meibomian cyst, is an acute infection of the meibomian gland and appears as a small rounded swelling away from the margin of the eyelid. The sty will disappear quickest by removing the lash at the affected point and applying heat several times a day. The acute chalazion partially subsides with heat but after the acute signs have passed a small mass remains which should be excised at a later date.

Another differentiation is that between conjunctivitis and iritis. The former is most often bilateral; there is a discharge, pain is rare, and the redness is greater away from the edge of the cornea. In iritis there is pain, no discharge, photophobia, pupil is small, cornea may be cloudy, and the redness is greatest at the corneal edge. If you are sure it is conjunctivitis instil 30% sodium sulfacetamide every three hours for two days. If the condition does not improve or if you suspect iritis in the first place refer to an ophthalmologist. If conjunctivitis occurs in several employees, school children, or members of a family within a week, conjunctival cultures should be taken of all affected eyes and investigation made to seek out the contagion.

Hot bathings of an affected eye are often ordered while the patient remains at his place of employment—e.g., in a case of sty or chalazion. The best procedure, one which causes no burn to patient or nurse and attains the maximum heat, is through the use of a wooden spoon whose bowl is covered by cotton wool. The

patient holds the spoon handle, dips the bowl into a pot of steaming water, and gradually brings it towards the affected closed eye. First the steam heats the eyelids then the covered bowl itself can soon be applied to the lids. When it cools, dip again in the steaming water and repeat. Such hot bathing should be carried on for at least 15 minutes and repeated every three hours.

This constitutes a summary of simple first aid procedures in cases of eye emergencies and the recogni-

tion of the common eye conditions which may be seen by nurses. Aseptic technique should be maintained, sterilizing all equipment before using it in a subsequent case in order to avoid contagion. The necessary equipment is as follows:

Irrigating flask, eye pads, cotton balls, adhesive, applicators with cotton wool heads, medicine glasses, lamp preferably on a stand, large condensing lens, $\frac{1}{2}\%$ pontocaine, 2% fluorescein, 30% sodium sulfacetamide, goggles, dark glasses.

Detachment of the Retina

JEAN McCULLOCH

Average reading time — 10 min. 24 sec.

IN PREPARING this material, I sincerely appreciated the opportunity of visiting one of our doctors who was receiving treatment for detachment of the retina. His description of the onset, with cause and symptoms, and also discussion of treatment made this a truly interesting assignment.

RETINAL DETACHMENT

The retina is the most delicate structure of the eye. It is connected with the subjacent choroid at the entrance of the optic nerve and at the ora serrata. Rays of light which fall on the retina are converted into nerve impulses which are carried by the optic nerve to the brain.

Retinal detachment is a separation of the retina from the choroid. Detachments are produced by a force which pushes the retina from the choroid or by a disease of the vitreous which pulls the retina from its bed. These forces may be:

- (a) Inflammation and exudation—i.e.,

exudation of the choroid following acute choroiditis, renal retinitis, orbital cellulitis, acute scleritis, and similar conditions; (b) choroidal tumors; (c) injuries.

In a myopic eye there is an elongated eyeball with a resulting traction on the retina induced by ocular movements.* If these eyes become inflammatory, adhesions may form between the hyaloid membrane and retina; retina and choroid. Trauma or straining on these adhesions may be caused by:

- (a) Excessive forward bending of the head to pick up heavy objects from the floor; (b) putting on one's boots; (c) gardening or similar occupations.

Therefore, it may be seen that the part played by trauma is purely casual as trauma breaks that which was at the point of breaking. Some doctors advise moderation in or abstinence from drinking and smoking following retinal detachment as they feel this may have some effect on the predisposing cause.

Rents in the retina may occur without detachment. This is shown when traumatism occurs. Weeks or months may elapse before detachment occurs, as the retina does not detach until the edges of the wound are drawn

Miss McCulloch, a V.G.H. graduate, prepared this material while she was a member of the post-graduate group in operating room technique at the Vancouver General Hospital.

towards the interior of the eyeball.

The patient usually first notices a sudden loss of vision in one part of the visual field, usually large and curved towards the interior of the eye. The patient complains of a "floating crescent" in the visual field or, if the tear is ragged, the shadow or curtain is "star-shaped."

The development of the tear varies greatly in different cases. Within a few hours the retina may become extensively detached due to the passage of fluid between the retina and choroid and, if untreated, this detachment may progress until a greater part of the retina is detached with almost complete loss of vision in that eye. More frequently the rent is small at first and increases as the days pass. Small rents may continue indefinitely without increase in size.

Upon ophthalmoscopic examination the area of detachment appears as a collection of greyish-blue or greenish folds projecting into the vitreous and shaking with movements of the eye. Careful search of the separated area usually reveals a hole. Detachment may occur anywhere on the retina but usually occurs on the temporal side. If it occurs at the ora serrata—i.e., point of insertion of retina—it is known as disinsertion. This latter tear cannot be seen with an ordinary ophthalmoscope. A gonioscope is used.

Examination of the visual fields reveals a loss of vision in that part of the field which is opposite to the detachment.

MEDICAL TREATMENT

The patient is put to bed at once. He is placed on an "eye" mattress (this is a spring-filled mattress with a thinner mattress on top) with no rubber drawsheet and one pillow. In most cases the patient must lie flat on his back, but if the detachment is on the temporal side of the eye the patient may lie on the side of the injured eye. Complete bed rest is essential. Two nurses are needed to turn the patient—one to hold the head and one to roll the patient, if this is allowed. The patient is not

allowed to shave, his diet is a "no-chew" one, and no aperient or enema may be given unless ordered by the doctor. Atropine drops 1% are instilled in both eyes b.i.d. This causes contraction of the ciliary body and rests the iris. The choroid is not pulled back and forth. Thus, if a spontaneous attachment should occur the retina would not be pulled away again. Pinhole glasses are applied immediately upon admission thus putting both eyes at rest as completely as possible.

Although rare cases of spontaneous reattachment have been reported following complete bed rest, the only effective treatment is surgical. The operative method now favored is that of diathermic coagulation aimed at creating a line of traumatic adhesive choroiditis around the hole or tear in the retina; when the sub-retinal fluid is allowed to escape, the retina falls back into position and reattaches itself to the choroid at these points. Early operation is necessary as results are seldom obtained if the detachment has existed longer than six months.

PREOPERATIVE PREPARATION

1. Immediate preoperative care on the ward:

(a) An enema may be ordered the night previous to operation.

(b) A thorough physical examination is done.

(c) A preoperative medication is ordered such as demerol or hyoscine—*never* morphine as this contracts the pupil.

(d) The patient is taken to the O.R. on a stretcher.

2. Immediate preparation in the operating room:

The patient is taken to the eye room, which is a dark room with the blind drawn during operations, and placed on a soft mattress on the eye table. Two small sandbags are placed on either side of the patient's head to hold it steady. The graduate nurse in charge of the room receives the patient and begins the local anesthetic by putting pontocaine ½% drops q. 5 min. for 20 minutes. Then, with gloves on, she proceeds to bathe the eyes, forehead, and face and then both

eyes again with absorbent and a solution of equal parts of saline and aqueous zephiran. The operative eye is then irrigated with the same solution. Having asked the patient which eye is injured and also checking with the chart, the scrub nurse proceeds to drape the head covering the good eye. Before gowning, the surgeon paints the operative area with an antiseptic—it may be iodine and alcohol solution or aqueous zephiran 1: 1000. The surgeon then proceeds to inject a local anesthetic—usually novocain 2% with or without adrenalin. A retro-bulbar injection is also made with 2" No. 26 gauge needle. The eye is again irrigated with saline and aqueous zephiran and an eye sheet is applied. The surgeon is then gowned and gloved and proceeds with the operation.

OPERATIVE PROCEDURE

The retinal tear is located. It is usually on the temporal side but, of course, may be located anywhere in the retinal area. A large semi-circular conjunctival flap is made with scissors over the tear. The external rectus muscle is caught and detached if necessary. Black silk sutures are inserted in the muscle to be used as traction and turn the eyeball so that the area to be punctured is exposed. This area should involve a sufficient amount of sclera to include much healthy retina beyond the limit of the hole. A fine iridium-platinum needle or multiple Walker needles are used—these are attached to a Rose Walker or diathermy puncture machine. A weak current, 40 to 60 milliamps, is used. Multiple punctures are made in a semi-circular way from the ciliary body. The operator allows the needle to remain in contact with the sclera for about one second in each puncture.

A second or even third barrage of punctures is made further away from the localized site of the tear. The object is to puncture the sclera and stir up congestion in the underlying choroid without penetrating the choroid or sub-retinal space. As soon as the desired number of punctures have been made, the needle is again inserted into the openings and carefully made

to penetrate the sclera and choroid into the sub-retinal space. The sub-retinal fluid will be seen to exude through the openings. The eye is then inspected with an ophthalmoscope to see if the barrage has covered the desired area and also to make sure that the retina has become flat after punctures through the choroid. The muscle tendon is sewed into place and the conjunctiva sutured. Atropine 1% drops are instilled as well as penicillin solution. Metaphen ointment is applied to both eyelids and both eyes are covered with eye pads and shields held on with Scotch tape. The patient is then wheeled to the ward on the operating table and very carefully moved from the table to the bed with a nurse supporting the head.

POST-OPERATIVE NURSING CARE

The patient is placed again on complete bed rest. All preoperative orders—metaphen ointment, atropine drops, codeine gr. $\frac{1}{2}$ h., phenobarbital t.i.d.—are continued for the first two days post-operatively. Vitamin B is given as a tonic and vitamins C and K are given to prevent sub-retinal hemorrhage. On the 5th day an enema is usually ordered and by the 10th day the bed may be raised 10° increasing 30-60°. Usually by the 16th day the patient is allowed up but is cautioned against sudden movements, stooping over, or over-exertion. If the retina is in place and has not again begun to detach the patient is discharged at the end of three weeks post-operatively. Essential points in nursing care include:

- (a) Avoid sudden or loud noises.
- (b) Warn patient of your approach—speak quietly when entering room.
- (c) Room darkened before dressings are removed.
- (d) Explain how much and how little patient may move.
- (e) Patient is fed for two to three weeks. Make meals as interesting as possible.

PROGNOSIS

The outcome of this operation seems to be more and more favorable

with the use of diathermy puncture. A great deal of the success of the operation depends upon the age of the patient, the amount of detachment, and how soon the operation is done. Moreover, the complete co-

operation of the patient aids greatly in final success. Therefore, the patient should be given an adequate explanation of the importance his cooperation plays in the ultimate result.

The Chemotherapy of Cancer

PHYLLIS BREWSTER TAYLOR, PH.D.

Average reading time — 16 min.

AS A RESULT of increased public interest in the cancer problem, followed by increased governmental and private grants for research, considerable progress in this field has been made in the last few years. Significant advances have been made both towards the elucidation of the nature and causes of cancer and towards specific methods of treatment.

A large volume of research is being published on the chemotherapy of cancer. Many compounds are known to be toxic to cancer cells; researchers are now directing their efforts towards modifying these structures so as to decrease their toxicity towards man and thus increase their specificity against cancer.

FOLIC ACID DERIVATIVES

A number of derivatives of folic acid (pteroylglutamic acid) have received clinical trial. Aminopterin (4-amino-folic acid), known to be an antagonist of the parent acid, injected intramuscularly into 16 infants and children suffering from acute leukemia caused marked improvement in 10 of these. Certain conjugates of folic acid accelerated the leukemia; thus, pteroyldiglutamic acid (diopterin) aggravated the con-

dition in cases which later responded favorably to aminopterin.¹ On the other hand, clinical trial with 90 patients indicated that pteroyldiglutamic acid and pteroyltriglutamic acid are beneficial in the treatment of some malignant diseases.²

It is interesting to note that chicks maintained on a folic acid-free diet do not develop tumors when inoculated with Rous sarcoma virus. Also, the development of tumors in chicks on a normal diet is prevented by the folic acid antagonists—4-amino-folic acid, 4-amino-folic acid with D(-)-glutamic acid and 4-aminoaspartic acid.³

NITROGEN MUSTARDS

Methyl bis-(B-chloroethyl) amine and related compounds frequently induce temporary remissions in Hodgkin's disease, polycythemia vera, and lymphosarcoma. The toxicity of these compounds limits their use.^{4, 5} Apparently all rapidly proliferating tissues are attacked by the nitrogen mustards, which are called "mitotic arrestors."

URETHANE AND OTHER DERIVATIVES OF CARBAMIC ACID

Urethane (ethyl carbamate) is a useful therapeutic agent in the treatment of chronic myelogenous leukemia. Approximately the same clinical and hematologic results are obtained as with standard x-ray therapy. Toxic symptoms are common, the chief being nausea and anorexia.⁶

Dr. Taylor is associate professor of pharmacy, University of British Columbia, Vancouver.

(Reprinted, with permission, from the *Canadian Pharmaceutical Journal*, Vol. 81, No. 24.)

It has been found that the administration of urethane to rats inoculated with leukemia cells prevented the development of lymphatic leukemia in 91.1% of the rats as compared with 16.9% of resistant rats in the controls.⁷

Paradoxically, urethane and some other esters of carbamic acid are effective carcinogenic agents for the production of lung tumors in mice. The relative potency of the ethyl, isopropyl and n-propyl esters of carbamic acid as carcinogenic agents is approximately 81:4:1. The carcinogenic effect is exerted against pulmonary tissue whether the urethane is administered intraperitoneally, subcutaneously, or orally.⁸

Two other esters of carbamic acid—phenyl urethane and isopropylphenylcarbamate—cause retardation of spontaneous mammary cancers in mice.

PODOPHYLLIN

Preparations of crude podophyllin and its active principle, podophyllo-toxin, cause severe tumor damage in test mice.⁹ A study of the action of these agents on tumor cells and normal embryonic mouse fibroblasts and epithelial cells shows that podophyllin has a selective damaging effect on the tumor cells.¹⁰

DYES

Certain azo dyes (e.g., germanin) have been shown to inhibit the growth of transplanted lymphosarcomas although only in doses toxic to the test animals.¹¹ In a study of 331 acridine compounds,¹² it was found that a number of them administered to tumor-bearing mice in their food greatly retarded tumor growth. These compounds did not prevent tumor growth or cause regression of tumors; they did slow the rate of multiplication of tumor cells. Most of the compounds that colored the tumors also caused retardation of tumor growth.

INORGANIC RADIOACTIVE COMPOUNDS

One of the radioactive inorganic agents being given clinical trial is a short-lived isotope of gold—Au₁₉₈. This isotope, which is prepared by

neutron bombardment of Au₁₉₇, has a half-life of only 2.73 days and is, therefore, useful in the controlled radiation of certain tissues inaccessible to the standard methods of radiation by x-rays. Radioactive gold, in the form of a stable colloidal solution, has been used intravenously in the treatment of diseases of the lymphoid system; colloidal solutions of Au₁₉₈ have also been used for direct injection into tumor masses.¹³

Radioactive phosphorus (P₃₂), in the form of a solution of phosphate, continues to be used in the treatment of myelogenous leukemia. P₃₂ provides a convenient method of giving generalized radiation without the disadvantage of radiation sickness. While it ordinarily does not prolong the life of the patient, it does cause a remission of the unpleasant symptoms for long periods.¹⁴

A study of the phosphates of the radioactive elements plutonium and yttrium has shown that, far from being therapeutic agents, they induce fibrosarcomas in test animals.¹⁵ There is evidence that arsenic, also, may be a carcinogenic agent,¹⁶ although arsenic compounds have been useful adjuncts to roentgen therapy in controlling myelogenous leukemia.¹⁷

Sodium fluoride and sodium azide have had a favorable effect in a number of cases of advanced cancer and leukemia in man.¹⁸

BACTERIAL PRODUCTS

It has been known for many years that the injection of certain bacterial products into test animals will bring about the necrosis of transplanted tumors. At the present time considerable research is being carried on to determine the mechanism of action of these products and to find preparations suitable for clinical use.

When mice, bearing transplanted sarcomas, are infected with certain organisms, a rapid destruction of tumor tissue occurs. Unfortunately, these organisms are usually themselves fatal to the animals unless they can be protected against the result of the infection in some way. For example, if tumor-bearing mice are

infected experimentally with *Clostridium histolyticum* and the infection controlled by injection of histolyticus antitoxin, the life span of the animals is prolonged beyond that of the non-infected tumor-bearers. That the tumor tissue is not completely destroyed is shown by the fact that mice treated with penicillin to eradicate the remaining infection develop large sarcomas.¹⁹ In another test, mice with carcinoma grafts were treated with *S. cruzi* endotoxin. The endotoxin prevented the development of tumors in 19 out of 43 mice and brought about definite inhibition of growth in the others. In an equal number of controls, all the tumors developed well. Where the animals were infected directly with *S. cruzi* organisms, the carcinomas receded in 30 out of 45 mice although the animals later died of the infection.²⁰

It has been found that a polysaccharide from *Bacillus prodigiosus* is able to bring about complete necrosis of tumors in experimental animals. Apparently, the tumor damage is due to vascular occlusion followed by hemorrhages throughout the tumor. In every instance, however, some peripheral cells survive and growth of the tumor is resumed.²¹

Another tumor-necrotizing polysaccharide has been isolated from *S. marcescens* but the clinical application is difficult because of its toxic effects. The distribution of the polysaccharide in mice, rabbits, and man has been studied by tagging the polysaccharide with a radioactive iodine atom.²²

ALKALOIDS

Several alkaloids are known to bring about tumor damage in mice. Two of these are emetine and colchicine. Colchicine has been given clinical trial in the treatment of animal tumors and human leukemia; however, its toxicity prevents the use of doses large enough to produce more than a temporary effect.

TUMOR ANTISERA

In experiments involving 220 young chicks it was found possible to protect

the birds against the injection of lymphoid tumor cells by incubating the tumor cells before injection with lymphoid antiserum. The antiserum was prepared from chicks that had received repeated injections of killed lymphoid tumor cells. Injection of the antiserum into birds bearing tumor implants caused a partial or complete suppression of the tumor growth.²³

CONCLUSION

Many theories have been advanced to explain the origin of cancerous tissue. Any such theory must account for the alteration in cell characteristics responsible for the differentiation of cancer tissue from normal tissue. In assembling and condensing the mass of data published in connection with the cancer problem, one cannot help being struck by one outstanding paradox: many agents known to be carcinogenic are being employed with favorable results in the treatment of malignant disease. Thus we have ethyl urethane, shown experimentally to induce pulmonary tumors in test animals but clinically effective in bringing about the temporary remission of leukemias. As another example, we might consider the experimental evidence regarding the relationship of hormones to cancer; while estrogens have been shown to be carcinogenic in some test animals and are widely suspected as causative agents in humans, they are used in the treatment of some malignant growths. Certain azo dyes retard tumor growth yet others are known to initiate the growth (e.g., the hepatic carcinogen p-dimethylamino-azobenzene). Even the powerful carcinogens such as 1, 2, 5, 6-dibenzanthracene are found to inhibit some types of cancer.

Two reports not directly related to the topic of chemotherapy, but of possible interest, may be mentioned here. It has been reported²⁴ that propylene glycol injected subcutaneously in rats causes leukemia. No report of leukemia arising from the oral administration of the glycol has been made. In view of the increasing use of this substance, both

as a solvent and as an agent for sterilizing air, further research is indicated to determine whether propylene glycol is actually a carcinogenic agent.

The effect of high frequency sound waves on cancer tissue is under study at one American university. The ultrasonic rays can be focused on the cancer tissue so that less damage to the surrounding tissue results than by x-ray irradiation.

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Home Thoughts from Afar

'Mid silvery birches, murmuring pine,
Where fairy sunbeams dance and shine,
I've lived and played these happy days,
And walked the rustic, rugged ways;
Beside the waters, deep and blue,
'Neath wide clear skies of sapphire hue,
Where moss the ancient rocks adorn,
And fragrance on the breeze is borne.

I've met dear folk from other lands,
Exchanged a greeting, shaken hands,
And when a kindred soul I meet,
We find a fellowship that's sweet.
Yet this communion never lends
The joy of tried and trusted friends,
Whose worth is proved across the years,
We've shared our work, our joys, our tears.

And so tho' here is rest and peace,
From daily toil a short surcease,
My thoughts turn back in time and space,
To see again each well-known face;
To hear each well-remembered voice
Will surely make my heart rejoice.
Oh, 'yes, it's nice at times to roam,
But, best of all, is coming home.

—M.M.F.

The Menopause

F. GIBSON, M.D.,C.M.

Average reading time — 7 min. 36 sec.

THE MENOPAUSE heralds the end of the reproductive life of the woman. The manifestations of this critical change have been recognized since the time of Hippocrates. Progress in the fields of physiology, endocrinology, and psychiatry have clarified some of the mysteries but many of the phenomena still remain enigmatic.

The menopause is that period of life characterized by a complexity of phenomena—the central symptom of which is menstrual cessation—but also accompanied by circulatory and psychosomatic manifestations. Strict interpretation of the term “menopause” would limit its use to express merely the cessation of menstrual flow. The more applicable term, “the climacteric,” describes the events which transpire during the transition from the reproductive period to senility. By tacit consent, however, the term menopause has won preference among the profession and the laity and will be employed to include all the events of this epoch.

It has been established without doubt that essentially all the phenomena are due to a gradual diminution in production of the ovarian hormone as a result of aging of the ovaries. A proper understanding of normal ovarian function is, therefore, necessary to comprehend the vagaries of the menopause.

It is generally stated that the human ovary at birth contains all the formed ova to last through a woman's reproductive period. Monthly, after puberty, one of these ova is involved in the formation of a follicle under the stimulation of the follicle-stimulating hormone liberated by the anterior lobe of the pituitary

gland, situated at the base of the brain. As the follicle grows in the ovary, it expands and develops a cavity filled with fluid containing the follicular hormone specifically known as “estrin.” This substance finds its way into the bloodstream to exert its influence upon the breasts, uterus, and vagina. When the follicle has reached maturity—the midpoint of the menstrual cycle—it ruptures and the ovum is extruded (ovulation). The collapsed follicle undergoes further changes and from this point, in its role as the corpus luteum, secretes progesterone which augments the effects of estrin upon the breasts, uterus, and vagina in the latter half of the cycle. With corpus luteum degeneration and consequent progesterone withdrawal the thickened endometrium is shed off and menstrual bleeding occurs.

By the end of the reproductive span, the ovaries are depleted of all their eggs by monthly ovulation and when the loss of ova is complete the ovary becomes inactive as an endocrine organ. It is at this stage that the change of life takes place. Follicular function may still occur without ovulation and this process accounts for the gradual diminution in hormonal activity in the presence of the cessation of the menstrual periods.

ONSET OF THE MENOPAUSE

Menopausal onset can be either a natural occurrence or artificially induced. The latter is provoked by:

(a) Radium insertion—or deep x-ray of sufficient dosage to cause atrophy of the ova and the follicular system.

(b) Surgical means — complete extirpation of both ovaries.

The symptoms in the two types are identical, except that in the artificially induced menopause the onset is more abrupt and the symptoms are usually more pronounced.

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The average age of onset is 45-50 years. Precocious onset has been recorded as early as the middle twenties and as late as the nineties.

The menopause, like puberty, depends upon the individual's potentiality. If the ovarian function starts early, indicating a virile gonad, its function will have a tendency to last longer with a natural delayed menopause. Conversely, late puberty bespeaks an early menopause.

Racial extraction appears to have some bearing upon the age of onset. Northern and Anglo-Saxon types tend to be later, while southern and oriental types tend to be earlier in onset than average.

Obese women are likely to have some endocrine upset and for this reason have an inclination toward an early menopause.

Climate, race, and previous state of health all affect the onset. Ovarian function is exhausted early in women weakened by chronic diseases.

SYMPTOMS

The gradual diminution or sudden cessation of estrin production is probably the immediate endocrine cause of menopausal symptoms. The essence of the menopause is the cessation of menstrual flow. This may occur in the following ways:

1. Gradual diminution in flow from month to month.
2. Increasing intervals between periods.
3. Alternating months of reduced flow and excess flow.
4. Irregularity as to intervals and amount of flow.
5. Sudden cessation of flow.

The duration of this change may last between six months and three years. The symptoms can be listed generally as follows:

1. Hot flushes—which are essentially evidence of vasomotor instability. They can be described as a sudden sensation of heat and burning which sweeps over the body, reaching the greatest intensity over the exposed surfaces. An intense flushing of the face is sometimes visible. A feeling of suffocation as well as faintness is often described. Beads of perspiration

may sometimes follow the flush. The frequency and intensity of the flushes vary from individual to individual. They may be so pronounced in some women as to awaken them at night.

2. Palpitations.

3. Emotional instability — usually mild, as evidenced by: (a) Fatigue, (b) insomnia, (c) weeping, (d) headaches, (e) dizzy spells.

4. Flatulence, constipation, and vague, diffuse abdominal pains.

5. A tendency to altered fat distribution and obesity.

6. Eczema, pruritus, and acne may appear.

7. Vague diffuse joint pains (arthralgias).

It should be emphasized that all symptoms do not occur in one individual. It is more common to find one symptom predominant or a combination of several. It has been estimated that about 85 per cent of women pass through this period without any disturbances of consequence. Of the remaining 15 per cent, the majority have only mild disturbances, while it is the rare case that exhibits significant changes.

TREATMENT

The management of the menopause can be dealt with in two phases—general and specific.

General management: In spite of a healthy attitude generally among women as to the significance of the menopause, there are still many misconceptions. All women at the menopause, or preferably before, should be reassured that the menopause is not a period to be dreaded. They should be firmly advised that it is a period of glandular readjustment as a result of aging of the ovaries and many of the symptoms are natural phenomena, which, if sufficiently severe, can be relieved by the proper therapy. All fears and superstitions should be eliminated. Every woman should be made to understand that the menopause does *not* usher in any change in libido, of facial or body configuration, or personality changes bordering on insanity. The first step, then, is *reassurance and the elimination*

of fears and superstitions. If the symptoms are mild then reassurance may be all that is necessary. Mild sedation may be required.

Specific therapy: When the symptoms are moderate or severe then specific therapy is indicated. This consists of oral or hypodermic doses of hormones. The hormones used may be either the ovarian hormones, estrogen and progesterone, or the male hormone, testosterone. Synthetic estrogens, such as stilbestrol, are the most popular because of their minimal cost, yielding at the same time a corresponding potency to the natural estrogens.

Initial therapy consists of daily doses of the hormones sufficient to control the symptoms with gradually decreasing maintenance dosage to maintain control. Women should be advised that medication must continue over a long period of time.

POST-MENOPAUSAL PERIOD

Any woman who experiences bleeding or spotting following the complete cessation of menstruation should consult her physician. Cancer of the cervix and uterus are most common during this period.

SUMMARY

1. The phenomena of the menopause are due to gradual diminution of estrogen production as the result of aging of the ovaries.

2. It is not a period to be dreaded, not all women have symptoms, and all those who do can be relieved entirely by proper therapy.

3. Treatment consists of: (a) reassurance, elimination of fears; (b) sedation; (c) replacement hormonal therapy.

4. Irregular bleeding during or after the menopause is the signal to consult your physician.

Building Maturity

CECELIA MAY SCHRAM

Average reading time — 5 min. 36 sec.

I PICKED UP my son's spelling paper today, glanced quickly over it for errors and, seeing none, rolled it up and threw it away. I had words ready if he had made many mistakes but no words for this surprising perfection! Startled by this thought, I removed the paper from the waste-basket, smoothed it out, and placed it on the kitchen table. There it would remind me to say the words a good spelling test deserved.

Many parents forget at times to give their children the appreciation and praise they deserve. Words of criticism come easily and are apt to become a habit. It would be helpful if parents were reminded to watch the words they use each day. Too often mistakes are emphasized and

opportunities for praise are thrown into the waste-basket.

In his book, "The Substance of Mental Health," Dr. George H. Preston emphasizes again and again the importance of love and praise to a child in building sound emotional and mental maturity. He gives first place to an understanding love and second to praise. Dr. Preston says that love is the first element and "praise is the second element which is necessary in a home if that home is to provide a firm foundation for mental health." Praise gives the child confidence in himself and love gives him confidence in other people. The two together build up an inner security that helps the child in all his future relationships.

Both praise and love must be expressed in words. A mother may tell everyone else how much she loves

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her child, yet neglect to tell the child himself.

John's mother loves her small son very much, yet she is always finding fault with him. His hair is not combed! Can he never remember to clean his teeth? What a stupid boy he is to lose his cap! How can John know that his mother loves him?

Children think that their parents know everything. If their father or mother continually calls them stupid, they believe they *are* stupid. "Children learn to estimate their own value in the world from the opinion of their parents." If children are made to feel ignorant and unwanted in their own homes, they will feel the same in their contacts away from home. Words of love and praise can give a child a sense of his own worthwhileness.

Recently, I had reason to be interested in a case which convinced me more than ever of the importance of love and praise in the parent-child relationship. It was about a year ago that a friend of mine came to me, very much disturbed about her ten-year-old boy. This is the story as she told it to me.

Summer vacation had been very enjoyable that year. There was closer contact and warmer relations among all the members of the family than there had been for years. Father's financial worries were much less now and mother and sons seemed to find new life under the lessening of tensions. Then school began for the fall term.

The first day of school, ten-year-old Tom went as far as the school door and then came home crying and shaking. He was clearly terrified and could not force himself to go into the school. He was a reasonable child and knew that he was behaving unreasonably, yet he couldn't force himself to act in his usual normal way. Every day for weeks he started out for school two or three times, only to return home again and again until he could summon up enough courage to go into his classroom.

If this had ever happened before, Tom's mother would not have been as concerned as she now was. Even in his kindergarten years, Tom had never been

upset about going to school. Now, any separation from his mother had become a terrifying experience.

Tom refused to stay alone even for a short time. He cried when his parents would go out for the evening and leave him with friends. He gradually withdrew from his own friends and spent his time reading or listening to the radio. His mother was overwhelmed that her seemingly happy little boy should have developed into this fear-ridden, agitated child.

We checked with Tom's teachers to see if there was any trouble there that might relate to this condition but found everything at school entirely satisfactory. His mother took Tom to a doctor to see if there was anything wrong with him physically but found his health to be excellent. Now we decided to consult with a psychologist that we both knew and the advice that this woman gave Tom's mother is the same as that which should be given to every mother—"Love your child more and don't be afraid to tell him that you love him!" Tom's insecurity could only be overcome by the assurance that both his parents were proud of him and that they both loved him. Somewhere along the way he had lost the assurance that he was important to his family and that he was really wanted.

It is easy for a child to get the impression that he is not loved enough or wanted by his family. Sometimes a younger brother or sister demands so much attention that the older child feels left out of the group. Sometimes mother and father are so busy with their own problems that they forget to take time to listen to their children and take an interest in their affairs.

In some cases, the parents are so anxious to have children that conform to all the rules that they spend the time they should be loving their children in nagging them. It would help if parents occasionally took word inventory—how many times they said "stop," "don't" and "behave" against the number of times they found opportunity to give praise and affection.

Tom is a much happier boy now. When both parents realized how much

he needed their attention, it was only a matter of time until he became more sure of himself. He is not entirely cured. It took years for this feeling of insecurity to develop and it will take years for it to entirely disappear.

Tom's parents were like many other parents in that they had not consciously neglected him—they had only been thoughtless. They knew that they loved Tom and they thought he knew that they did. He was a good, quiet child and had never demanded special attention; consequently his need for attention had not been realized.

So let us remind parents that children need to be *told* that they are loved and that their mother and father are proud of them. Children need warmth and affection to grow to a healthful maturity. They need to be hugged and kissed once in a while. The toughest little "cowboy" on the street still wants those kisses, though he wouldn't admit it for the world.

Don't let those mothers and fathers forget to give their children the love and praise they deserve. As Dr. Preston says, "It cannot be any fun to be little and weak and always wrong and to have it rubbed in."

Naval Medicine

WALTER M. LITTLE, M.D.

Average reading time — 7 min. 12 sec.

YOU MAY ASK what qualifications I have to discuss naval medicine. From 1942 till 1945 I served in the Royal Canadian Naval Volunteer Reserve, not as a medical officer but as an executive officer. When I joined the navy I had completed three years of medicine at the University of Toronto. On discharge in September, 1945, I returned to medicine. However, the navy was still of interest to me and I joined the Naval Reserve—first as an executive officer (retired) and then, after obtaining an M.D., as a Surgeon Lieutenant in the active reserve.

What is the organization of medicine within the navy? The department is headed by a surgeon captain. Administrative policy is handled from Ottawa. Roughly speaking the chain of command passes from Ottawa to the Command Medical Officer in the various commands and then to the main hospitals. We will consider the East Coast as I am more familiar with

the organization there. The Command Medical Officer is responsible for all medical organization and services within the command. He has the Royal Canadian Naval Hospital in Halifax—a large, modern, fully equipped hospital. This is equipped to handle all aspects of medicine and surgery and their allied specialties. There are various sick bays at the smaller ports: In the dockyard at Halifax there is a good-sized sick bay which is the naval version of a general practitioner's office. It handles the men from the dockyard and from the ships not large enough to carry a medical officer. Men requiring hospitalization are sent to the R.C.N. Hospital. In most of the smaller vessels with no medical officer there is a "tiffy"—a sick berth attendant who is a combination of male nurse, pharmacist, and jack-of-all-trades. Aboard the larger ships—frigates, destroyers, etc.—there is a medical officer with at least one "tiffy." These ships are fully equipped to handle any emergency, an appendectomy, or even major surgery. Major surgery is avoided and transferred ashore, if

Dr. Little presented this material in an address to the Goderich (Ont.) Community Nursing Registry.

possible, because it is felt that the added difficulties of an operation at sea are an unnecessary added risk to the patient. Consequently, conservative therapy is the rule when possible. There are also some small harbor craft attached to the sick bay in the dockyard to transfer sick men from a ship to shore.

At the R.C.N. Hospital in Halifax there is a Well Baby Clinic for the children of naval men. To this clinic, two afternoons a week, the mothers bring their young children for physical examination, changes in formula and feedings, and immunization. Approximately 30 babies are seen each afternoon. There is a full-time nursing sister at the clinic as well as the medical officer who is there each afternoon the clinic is open.

What are the duties of a medical officer in the active reserve? He examines recruits, both for the permanent service and the reserve, lectures in first aid and other medical subjects, and attends to any medical emergencies that may arise during the three-hour parade each week. In addition he must spend at least two weeks a year on active service, either in a sea-going ship or at the R.C.N. Hospital (or some similar appointment). The reserve medical officers are also kept up to date in navy matters by occasional refresher courses.

What are the requirements for and the advantages of being a medical officer in the permanent force? The man must, of course, have a medical degree and be of suitable character and personality to be likely naval material. He should be of a type that will be "happy in the service." His pay is not large when compared with the income of the average civilian doctor. It is in the neighborhood of \$4,400 per year for a Surgeon Lieutenant (married) but this is almost pure profit. The navy supplies all instruments, books, and professional magazines. The hours are reasonable with a minimum of night calls. The atmosphere is pleasant and he is dealing with a relatively healthy group of men who suffer as a rule from acute conditions with a minimum of chronic complaints. One

year in five is spent in a sea-going ship and one year in five in a civilian teaching hospital taking post-graduate training in whatever specialty the doctor wishes.

One of the recently publicized advances in naval medicine is the provision of a sea-sick remedy. The formula has been released to civilian doctors. It is also of value for other forms of motion sickness such as car sickness. Until the past war, therapies for sea sickness were largely based on the individual experiences of the advocate of the particular remedy and not upon tests with adequate controls. However, in 1940, when it was obvious that a large-scale invasion would be necessary to regain Europe, the National Research Council, in co-operation with similar groups in the U.S.A. and Great Britain, began to study the problem. Trials on swings were used, preliminary to trials at sea. The formula recommended by the National Research Council contains hyoscine hydrobromide, hyoscyamine hydrobromide, and a thiobarbiturate.

Public health and preventive medicine play a large part in naval medicine. Let us consider some of the obstacles and the methods of overcoming them:

Crowded conditions: This factor plays a very important part in the spread of communicable disease. When you consider that 40 men eat and sleep in a space approximately 30 feet by 30 feet and low enough to require a tall man to duck to avoid the pipes you can understand the problem. In the newer ships they are separating the eating and sleeping quarters. This, of course, requires larger ships than before. In the newer ships they are experimenting with folding bunks instead of the traditional hammock. The hammock requires little storage space when rolled and in a heavy sea the ship rolls about the hammock and it is, therefore, easier to stay in a "mick" than in a bunk. Due to the crowded conditions it is often necessary to quarantine the whole ship if an epidemic breaks out aboard.

Water and sanitation: The provision of good drinking water at sea is a problem. Fresh water must be carried or distilled from salt water at great expense. The fuel

used for this purpose may be of value to get the ship into port after a long run. Consequently, fresh water for showers and washing of clothes at sea is prohibited or greatly restricted. Salt water is used for sanitary facilities.

Clothing: This should be as light, as warm and as easy to keep clean as possible for the North Atlantic in winter. The usual dress for look-out duty in winter consists of two long woolly suits of underwear, two or more trousers, several sweaters, a long naval scarf, woollen mitts, balaclava for the head, a sheep-skin-lined coat, heavy waterproof boots, and possibly oilskins over this. One looks like "Mr. Five-by-Five!" During the war a light-weight warm suit, complete with several zippers, was developed to cover one from the top of the head to the ankles. Other improvements have or are being developed in the clothing line.

Preparation of food: The galley is very small but it is a very important essential. It is about the size of an ordinary kitchen. Here are prepared the several meals and snacks for a crew of over 100 hungry men. In addition to the problem of limited space there are the difficulties presented by a rolling ship. The stoves are fitted with "fiddles"—iron bars which divide the stove top into several small compartments to keep the pots and pans from shifting. In spite of all the difficulties, shipboard meals are usually very good.

Life-boat equipment has received the

attention of the medical profession. In place of the old-fashioned hardtack—that brick-like biscuit—we now have tinned and water-proofed packaged foods of high nutritional value.

Progress has been made in both the prevention and cure of *venereal disease*. The former has been accomplished through education and a common sense approach to the problem as well as provision of prophylactics. The latter has been achieved by the use of sulfa drugs and penicillin. Without quoting any figures on the subject let me use an example. There were very few times that our ship sailed in 1942 without leaving at least one man in hospital with gonorrhea. In 1945 I do not remember leaving one man behind because of this disease.

Immunization plays a very important part in naval medicine. In addition to the usual immunizations—smallpox, diphtheria, typhoid, paratyphoid A and B, tetanus, etc.—men received immunization for any special diseases to which they were likely to be exposed (when immunization was available for the disease).

This has been merely an introduction to naval medicine, a mere skimming of the surface, but it does help to give an idea of what goes on behind the scenes. The various techniques, therapies, and experiments of civil medicine all have their counterparts in naval medicine.

Growth Differences

Individual differences in the growth of a selected group of people from the prenatal period to death and through several generations of their descendants will be investigated in the United States. The purpose of the study is to correlate physical, mental, and emotional factors over a long period in order to develop more reliable methods for determining patterns of normal and healthy growth. The project is under the direction of Dr. Alfred Hamlin Washburn, of the Child Research Council, Denver, Colorado.

Continued investigation of 166 persons will be made by 20 research workers in such fields as pediatrics, physiology, biochemistry, hematology, nutrition, and psychiatry. A

single aspect of the study will involve the physical and physiological changes of the head, teeth, skeleton, sinuses, and lungs as revealed by periodic x-ray.

—U.S. Public Health Service

The first step toward getting along with people is to build the habit of looking for their good qualities. If you look, you will find them. Conversely, one can easily fall into the tragic, self-defeating habit of disliking people, by thinking of and looking for only the mean, small, despicable qualities in humankind.

—K. C. INGRAM

Hints on General First Aid

O. HOFFMAN, M.D.

Average reading time — 6 min. 24 sec.

INSTEAD OF A formal outline of first-aid treatment it is proposed to discuss certain injuries with emphasis on the principles which guide one's choice of procedure. There is considerable variation of opinion regarding some aspects of first-aid treatment and it should be understood that this information offers but one opinion in these matters. Four major groups of injuries will be discussed: wounds; soft tissue injuries with intact skin; fractures; burns.

WOUNDS

These are injuries in which the continuity of the skin surface is interrupted. Our chief concern is the control of infection, following which we wish to put the injured tissue at rest and allow natural healing processes to restore structure and function as completely as possible. The time factor is important in controlling infection. Wounds receiving treatment within six hours of the time of injury can be given the benefit of primary closure. After six hours the incidence of a complicating infection rises sharply.

(a) *Antiseptics*: When the skin surface is intact, strong antiseptics can be used to kill bacteria without injury to the body tissues (iodine and alcohol, anilines, mercurials, quaternary ammonium compounds). In an open wound an antiseptic strong enough to kill most bacteria is also strong enough to injure or kill body tissues, which are already damaged. This interferes with normal healing processes and provides a medium for the growth of bacteria which may gain access to the wound after the antiseptic has been used. Hydrogen peroxide is relatively harmless and may be used to irrigate a wound. Where gross contamination has occurred powdered sulfathiazole is favored by

some physicians. The most widely accepted routine is to wash the adjacent skin area with green soap and normal saline under aseptic conditions. The wound may then be irrigated with freely running normal saline.

(b) Any hair in the wound region should be clipped.

(c) *Débridement*: Any foreign material in the wound should be removed as well as obviously devitalized tissue.

(d) *Closure*: In gaping wounds: sutures or clips. The latter are useful in areas where surface skin is loose and where cosmetic results are not of primary importance. Adhesive tape "butterflies," sterilized by flaming, are sometimes enough to keep tissues in apposition.

(e) *Dressings*: In primary closure of a clean laceration a dry dressing is adequate. In abraded or irregular wounds sulfathiazole emulsion is a satisfactory dressing. Rest the injured part. Do not change the dressing unless it becomes contaminated or unless there is evidence of infection in the wound. Adherent dressings should be moistened with sterile saline or peroxide before removal is attempted. Deep punctures or badly contaminated wounds indicate the use of anti-tetanus serum.

In wounds of extremities (particularly hands and fingers) watch for evidence of damage to nerves or tendons. Dressings on individual fingers may be kept in place by a cylinder of adhesive tape, with the adhesive side outwards, placed along an uninjured part of the finger before the dressing is applied.

SERIOUS WOUNDS

First concern is control of bleeding which, in 90 per cent of cases, is achieved by direct pressure on the bleeding area. Then treat or prevent development of shock: elevate feet; maintain body warmth; morphine; oxygen inhalation if available.

Dr. Hoffman is with the Civil Service Health Division, Department of National Health and Welfare, Ottawa.

SOFT TISSUE INJURIES

In injuries with intact skin, such as bruises, sprains, strains, our primary aim is to prevent swelling due to edema or gross bleeding into the tissues. Circulation through the region is diminished and swelling inhibited by: elevation of region, if a limb; cold compresses; pressure bandage.

After 48 hours switch to heat and as much free movement as can be tolerated without causing additional injury. Early movement is especially important in joint areas, if bone damage is absent.

FRACTURES

Avoid further damage by immobilization "where they lie" without manipulation. Splints can be improvised in many ways—e.g., tongue depressor as finger splint; pillow strapped firmly around fractured forearm or leg; opposite leg in fractures of lower limb; and so on.

In compound fractures cover the wound immediately with sterile gauze. Anti-shock treatment given routinely.

BURNS

The same principles apply as in treatment of wounds with modifications due to the nature of the tissue injury.

First degree burns: Slight injury to superficial vessels which dilate and produce erythema.

Second degree burns: Damage to vessel

walls allowing escape of serum from blood vessels into skin layers resulting in blisters.

Third degree burns: Where superficial tissue layers are destroyed.

Fourth degree burns: Extensive charring.

The burned area should be cleaned under aseptic conditions with green soap and sterile saline. The distress of this procedure may be lessened by first applying 5% novocain solution as a compress for 5 to 10 minutes. Foreign matter and dead tissue should be removed. Apply sulfathiazole emulsion freely; cover with fine mesh gauze or vaseline gauze; bandage; layer of cotton or cotton waste; outer bandage.

All materials used should be sterile. Immobilize the part and leave for from 5 to 14 days if free of infection.

General treatment is most important especially in children. It starts with standard anti-shock therapy and includes plasma administration. It is recommended that all burns be treated fully even though first inspection suggests they are minor.

Chemical burns are treated in the same fashion after free irrigation with copious amounts of water or saline to remove all traces of the chemical.

Tense painful blisters which develop—e.g., on fingers—may be drained under rigid aseptic conditions after 48 hours and redressed.

Yaws Control

A campaign has been launched in Thailand by the World Health Organization to bring yaws under control. Yaws is reported to affect at least 200,000 people in all parts of Thailand. It is estimated that four-fifths of those suffering from the infective stages of the disease are persons under 18 years of age and women of child-bearing age.

Yaws is an infectious, non-venereal disease occurring in the hot moist tropics. It is caused by *Treponema pertenue* and is characterized by an initial cutaneous lesion, the mother yaw, followed by one or more crops

of multiple, papillomatous, raspberry-like lesions of the skin. Occasionally late destructive lesions occur involving especially the skin and bones. The spirochetes gain entrance through the skin. Flies may be vectors.

The main function of WHO is to assist in training teams of Thai health workers who will endeavor, by systematic house-to-house visits, to discover all existing cases and to ensure the administration of penicillin to the infected persons.

—WHO Public Information Office

Lyle Creelman *Writes . . .*

Average reading time — 5 min. 48 sec.

FOR THE FIRST TIME nurses were on the program of the International Congress of Pediatricians which was held this year in Zurich July 24-28. It was attended by over 2,000 pediatricians from all parts of the world. Many scientific papers in relation to newer developments in pediatric practice were presented. A few were devoted to the social aspects of pediatrics and it was in this field that nursing appeared. Miss Una Robertson from New Orleans, who is at the moment a short-term consultant for WHO at the Ecole de Puériculture in Paris, spoke on "The Teaching Role of the Nurse in the Pediatric Ward." Miss Häcler from Switzerland had as her subject "The Nurse's Task in the Care of Premature Children." I spoke on "The Role of the Public Health Nurse in the Prevention of Infant Mortality." We were all limited to 10 minutes. As there was no translation, not all of our audience could understand each of us. It was an

opportunity which we welcomed, nevertheless, and we hope that in future congresses of this sort the nursing aspects of medical care will be included.

Following the Congress, there was a special program for nurses, attended by about a hundred, of whom 30 were from countries outside of Switzerland. Miss Fernande Riverin, of Montreal, represented Canada. These "Nurses' Days" were sponsored by the I.C.N. and the Swiss Nurses' Association. The first afternoon the emphasis was on nursing education and clinical supervision. Professor Sir James Spence, of Newcastle, gave a very provocative paper on "Co-operation Between the Doctor and the Nurse in Pediatric Service." I hope this will appear in our *Journal* so that you can all have an opportunity to read it. I would advise those who are interested in pediatrics to read any publications of Professor Spence. He is doing very interesting work in his field. Following his paper, a demonstration of clinical supervision was presented by a head nurse, a clinical supervisor, student nurses, and a young patient. The theme of this demonstration was carried through to the next morning when public health nursing was featured. To demonstrate the work of the public health nurse, there were scenes in which the student from the hospital was shown making a home visit with the public health nurse (to the home of the young patient who was, of course, already discharged). She was also shown participating in a child health conference. The use of clinical supervisors is just beginning in Europe and, as at home, provision is not made in many schools for student nurses to participate in home visiting and child health conferences as a part of their basic preparation.

Just a word about the city of Zurich itself. Its history goes back to "the third millenium before Christ.



Dr. Dorothy Nyswander, member of Expert Committee on School Health; her husband, Dr. George Palmer; Helen Martikainen, chief, Health Education, Public Section, WHO.



One of the flower floats in the Geneva Fête.

After the glaciers had retreated to the Alpine massif, pile-dwellings arose in the inlets of the lake, where fish were abundant, and their occupants lived above the water throughout the Stone and Bronze Ages, until about 800 B.C." Today, Zurich is the largest and most cosmopolitan city in Switzerland. It has lovely shops with most attractively dressed windows. To me, its charm lies in the old part of the city, with its narrow streets, its twin-towered Grossmünster built about 1100 A.D., St. Peter's Church, with the largest clock-tower in Europe—it was built in the thirteenth century—and, most attractive of all, the Rathaus, which is built on the water's edge. All of these buildings are illuminated at night throughout the summer season and along the streets there are many delightful sidewalk cafés where one can stop for coffee or drinks and remain the whole evening, just chatting and watching the world go by. Frequently in the background there is most delightful music, played by accomplished European musicians.

The week following the Zurich Congress, a seminar in social pediatrics was held in Geneva. This was

planned for pediatricians on UNICEF fellowships. We were permitted, however, to invite 10 nurses to participate. As so frequently happens in such a seminar, there were too many speakers and not enough time for discussion. There is still much study needed in conference techniques but, as you can well imagine, the problems are greatly magnified when planning a group discussion in which several languages are involved.

To round out the professional field of pediatrics, the following week we had a WHO Expert Committee on school health. At this meeting, we were privileged to have Dr. Dorothy Nyswander, known to many Canadian public health workers through her book "Solving School Health Problems." Nursing was represented on this committee by Miss Lindquist from Sweden. We discussed health services for the school-age child and tried to remember that our report should be helpful to countries such as Canada; to countries where there are more doctors than nurses; to those where there are no doctors or nurses at all for school work; and where there are not even schools. It wasn't easy!



More of the Geneva Fête parade.

Along with this series of professional activities, you will be glad to know that we also took part in some of the August festivities of Switzerland. Just as we celebrate July 1, so the Swiss celebrate their Confederation on August 1. Its origin goes back to 1291 when the three original cantons—Uri, Schwyz, and Unterwalden—drew up a document, written in Latin and referred to as the Eternal Alliance. It was the foundation of the Swiss state of today which now comprises 22 cantons. On August 1 every year bonfires are lighted on the mountains. Woodsmen collect their wood and each one tries to reach higher ground than the other. It is a lovely sight, from a boat on the lake, to see those fires burning far up on

the hillside. Due to the drought in some parts of Switzerland this year it was impossible to celebrate in this way but always in the mountain villages the people sing and dance.

And then, on the week-end of August 11 to 14, Geneva had its famous fête, also a yearly event. The highlights are the costume and the flower parades. This year the parade was led by a chariot drawn by four spirited bay horses and driven by "Roman soldiers." Joan of Arc, mounted on a black charger and followed by warriors in real coats of mail, was also in the parade and so was Don Quixote. The flower floats were magnificent, many of them drawn by beautiful white horses. The Swiss people are very original and artistic and anyone planning to visit Switzerland should arrange their trip to be in Geneva at this time of the year. On the Saturday night there was a 35-minute display of most elaborate fireworks and on Monday, to close the fête, the famous Carabinieri Band from Rome gave a concert, featuring classical music.

I nearly forgot to tell you about the "Bataille de Confetti" which follows every fête parade. This involves real group activity! Everybody buys special sacks of confetti which are on sale for one franc (about 25 cents). They parade along the section of the street closed off for the fête, throwing confetti at everyone they meet. The object, of course, is to catch someone laughing and with a wide open mouth! Very soon you find yourself buying another sack of confetti. It is a lot of fun and recommended as a good mixer!

Hearing Impairment

Because some 10 per cent of all school children suffer some impairment of their hearing and because certain of these conditions can be alleviated by a relatively simple form of radium treatment, Dr. Samuel J. Crewe, Adjunct Professor of Laryngology and Otology at Johns Hopkins University, proposes to test the practicability of a

deafness prevention program in lower schools. The present project will test 1,000 Baltimore school children in order to determine whether radium treatment is both effective and economical enough to be recommended for routine usage in regular school health programs.

—U.S. Public Health Service

Institutional Nursing

We Were Skeptics

SISTER PAULETTE FORTIER, S.G.M. and MARY O'HARA

Average reading time — 6 min. 24 sec.

THE GLARE of the ceiling spot was playing strangely on the operative field. The surgeon's hands looked tired and once more his penetrating eyes lifted an apprehensive glance at the clock . . . Two and a half hours since the first incision! But there would be only a few minutes more to go—he seemed to brace himself with this thought. The drainage tube had been secured in the large pleural cavity—now they were putting in the intercostal sutures.

A glance at the patient assured the surgeon that his breathing was not too labored, his color not too ashen, though he had lost a fair amount of blood. From the look of things everyone would survive the ordeal—everyone usually did—but for both of us these dreaded sessions meant a great deal of worry, sleepless nights, and what not. They were closing the skin now with interrupted silk sutures. A terse "Cut this shorter" and it was all over.

"Good work!" The words echoed in our ears; we drew a long breath, in fact the first long one we had had time for all morning. The surgeon stripped off his rubber gloves and walked out with his assistant and the medical attendant.

The atmosphere of the room was still emotionally tense . . . whatever it lacked in sweetness it certainly made up in stress; for pneumonectomies and lobectomies by the clever but at times irascible chief of staff were not humdrum affairs!

Drapes came off fast now. Time

was at a premium to get the patient back to the ward and into the oxygen tent. This was one of the numberless and important factors—to get the patient in the tent for ample oxygenation of the remaining lobe and the good lung. We always felt relieved after that.

From Room II, where we worked quickly and quietly, we could hear the chief's voice ringing out as it always does: "Lower and lingual lobes removed in the usual manner. Stump buried in the upper lobe. Closure in layers."

He was still sitting on the chair near the stenographer's desk signing operative reports when we came out of the room—he turned towards us, paused a moment, then said: "I'll do another one on Thursday". . . our hearts missed a beat—this was Tuesday; in two days, another one! With a quizzical smile he added: "You know, some day these lobes will be as easy to remove as an appendix." Such a blunt statement left us amazed. We hardly knew what to say. We just nodded dubiously; what else could we do? Then we asked for the diagnosis and booked the operation for the appointed day.

This meant more lost sleep over the difficulties we were bound to encounter. It also meant more planning for improvement of our techniques. There is always the gleaming goal of perfection just ahead for anyone working in surgery and we always try to attain it.

Thursday morning came around. We were ready—at least we thought we were! Our patient was a heavy woman in her late fifties. The surgeon had gone through the usual

Sister Fortier and Miss O'Hara provide an efficient surgical team at St. Paul's Hospital, Saskatoon.

ritual of scrubbing meticulously, donning gown, and he was thrusting his powdered hands deeply into the rubber gloves which were held for him and still we did not have the patient in the exact position!!! We tried to look composed and matter-of-fact while struggling to place her properly but we were intensely conscious of impatient eyes watching us above a tight blank mask. Finally it exploded—"Don't you know by now that the patient must come down the table another inch? You have both done this time and again"... and the succeeding words were lost in his mask...

A few minutes later the neat, long, curved posterolateral incision was made; the muscles rapidly divided, the seventh rib resected, and the parietal pleura promptly incised along the extent of the incision.

With the rib spreader in place, excellent exposure is obtained. We could see the left lung rise and fall against the chest wall. Spot-lights were quickly adjusted to suit the surgeon and gleaming instruments were slapped into outstretched gloved hands on the split second. The patient, under intratracheal inhalation anesthesia of cyclopropane and oxygen, was breathing away nicely while new life poured into her ankle veins from two citrated blood flasks hanging from a pole.

We were now well in the danger zone—and our patient's life entrusted to the expert hands of our thoracic surgeon. Everyone worked with automatic intensity, with the nervous promptness of a team that is prepared for anything. This, indeed, was a tough case and gave us, the two most skeptical of the group, plenty of cause to wonder and worry.

The following afternoon we went to the patient's room, peered intently into the oxygen tent, and what we saw there made us logically conclude that "her hour just hadn't come." Our one-day-old lobectomy was resting comfortably with a broad smile on her face. That was several years ago.

Today, under the same brilliant

cone of light, the same dextrous hands perform the same skilful work but under totally different conditions. It is also with an entirely different frame of mind that the same supervising team prepare the theatre.

During the years we have made case studies and improved our planning. Alert to suggestions and cognizant of changes in technique that have resulted in many ameliorations, we have gradually planned and improved our techniques and set-ups to the point where it is a pleasure now, not a nightmare, to go through an operation. Even the atmosphere is clipped of its tense and dramatic suspense. The terrific strain has given place to a breathless happy experience.

There is ease now around the operating table and hardly a terse remark. "Scalpel—sponge—forcep—ligature—scissors—" is all that can be heard to break the silence. Everyone seems to have that calm and collected attitude that comes with experience and confidence, even though at times the patient stands on the brink of death.

It is a worthwhile experience to have lived through moments like those of years ago and those of today. We didn't get a single grey hair over the entire period either, but that was sort of a miracle. Yes, we believe in miracles even in this age where faith seems so weak and rare. Now these cases are just "another operation." Patients come from every corner of the province and from many other points of the country, eager to be cured of their bronchopulmonary diseases.

Just the other morning, a 12-year-old boy was relieved of his left lower and lingual lobes in 45 minutes! In a fortnight he will be back home enjoying normal life again. Shock is minimized with speed like that and recovery is a certainty.

It was precisely after a case similar to this that a triumphant gleam came into the chief's eyes as he looked at us—a gleam that seemed to say: "I told you they would become as simple as removing an appendix." We couldn't help but smile at this great surgeon as though we were pretty

proud of him (and we were!).

In summer, elective time for this type of chest surgery, school age boys and girls afflicted with bronchiectasis come to be cured of their incessant tiresome cough—this ailment that drains all their energy. These children usually look forward to the operation; therefore their psychological adjustments are remarkable. For them it is simply the last step before their return to health and play and happiness.

Adults have just as good results only convalescence is longer. It always surprises us to see how little stress they go through following surgery. In fact, the mortality of partial pneumonectomy is less than 5 per cent, in recent years, in good-risk patients.

Naturally, to achieve these striking

results several factors are a *must*. These prophylactic measures before operation include: Several weeks of rest; treatment with streptomycin and penicillin aerosol; study of their bronchial tree with iodized oil; pneumothorax in certain cases and bronchoscopies. The anesthetist has to be a well-qualified and thoroughly competent individual to enable him to cope with the different problems he will certainly meet. Last and not least of the requisites is access to a good, well-equipped operating room with an adequately trained graduate staff.

Our thoracic surgeon is performing a difficult task in a modest and unostentatious manner and is making a substantial contribution to the welfare of those suffering from surgical disease of the chest.

In Memoriam

Elizabeth Anderson, who was a well known nurse in Ottawa for many years, died there on August 13, 1950, in her 90th year following a brief illness. Miss Anderson returned to Ottawa to practise following her graduation from Syracuse (N.Y.) Memorial Hospital many years ago.

* * *

Norah T. Christie, who graduated from the Montreal General Hospital in 1932, died in Montreal on September 11, 1950. Miss Christie had been active in nursing until recently.

* * *

Mary C. Johnston, a graduate of the Hamilton General Hospital, died in Toronto on August 19, 1950, in her 83rd year. She had practised in Toronto but had been retired for some years.

* * *

Annie (Craig) Kelly, who graduated from Chatham (Ont.) Public General Hospital in 1901, died recently.

* * *

Zella Marcellus, who had practised her profession in Ottawa since graduation, died suddenly on August 17, 1950, at the age of 25.

Agnes (Parley) McDowell, who graduated from Chatham Public General Hospital in 1933, died on April 11, 1950. For several years prior to her marriage, Mrs. McDowell practised private nursing. She was night supervisor at the Chatham Hospital for a time.

* * *

Edna Orr, who graduated from the Chatham Public General Hospital in 1928, died on September 5, 1950, after an illness of four months.



Wife, Chatham, Ont.

EDNA ORR

Following post-graduate training at Grace Hospital, Detroit, and the Ottawa Civic Hospital, Miss Orr was operating room supervisor at the Chatham Hospital. In 1941 she enlisted in the R.C.A.M.C., going overseas with No. 2 C.G.H. She saw service in England, France, Belgium, and Germany. Returning to Chatham, Miss Orr took over the reorganization of the medical records department, where she was in charge until her illness intervened.

* * *

Louise (Steel) Parker, who graduated from the Peterborough Civic Hospital in 1918 and later was superintendent there, died on August 19, 1950, at her home in Agincourt, Ont. Mrs. Parker had also held positions of responsibility in several U.S. hospitals prior to her marriage.

* * *

Jessie Margaret (Peele) Richmond, a graduate of the Royal Columbian Hospital,

New Westminster, died on August 23, 1950, after a long illness.

* * *

Annabell Ross, who graduated from the Chatham Public General Hospital in 1905, died early this year.

* * *

Letitia (Jones) Van Dusen, a graduate of the Toronto General Hospital, died in Toronto on July 24, 1950, in her 91st year after a short illness. In addition to private nursing, Mrs. Van Dusen had served as superintendent in hospitals in Montreal and New Jersey. She had retired at the age of 70.

* * *

Agnes White, a graduate of Aberdeen Hospital, New Glasgow, died on August 2, 1950, at the age of 75. Miss White had served as superintendent of Highland View Hospital, Amherst, for several years. After service overseas during World War I, she was supervisor of Murray Hill Hospital in New York.

Debunking the "R" Months

Oysters are edible the year around. They are fatter, more palatable, and more plentiful on the market during those months which contain the letter "R". The tradition that oysters must be eaten only in the "R" months may have originated somewhat as follows:

1. In that species of oyster eaten in the Old World for centuries, fertilization of the seed from which the baby oysters grow takes place within the shell of the parent oyster. Shortly before the baby oysters are ejected by the parent to fend for themselves, they begin to develop a shell. If the Old World oyster is eaten at this stage of incubation, the large number of almost microscopic baby oysters, each developing a shell, impart a gritty quality to the meat. Because the reproductive period of all oysters is in the summer, early settlers of this continent, cognizant of this but mindful of their Old World variety, avoided placing New World oysters on the menu until later in the year. It is only coinci-

dental that these months in which the oyster is most palatable happen to be the "R" months.

2. Even after our forefathers discovered that the North American East Coast oyster fertilizes its eggs in the sea water outside the parent shell, oyster consumption continued, for the most part, to be a winter activity. Partly responsible for this was the fact that only in recent years have refrigeration facilities been developed whereby oysters can be preserved in warm weather while being transported from the coastal growing areas.

3. Today, when perishable food products are transported thousands of miles by railroad and airplane, yet preserved by refrigeration, the greater portion of the country's shellfish consumers still clings to the old tradition. The advent of quality frozen oysters available throughout the year, however, may change this custom.

—U.S. Public Health Service

In women of 65 years of age and older, falls are responsible for three-quarters of all accident fatalities. Impaired vision and hearing, weakened skeletal muscles, and other physical deterioration make the aged

prone to falls. Moreover, accidents of this kind, which ordinarily cause little disability at the younger ages, often result in serious injury or death in older people.

—M.L.I.C. Statistical Bulletin

Public Health Nursing

The Teacher-Nurse Team

DOROTHY B. MARSHALL

Average reading time — 8 min. 48 sec.

ROBERTA'S PROBLEM belonged to her school teacher and nurse. Roberta was a rather tall, thin, nervous child and had been a new Canadian for nearly two years, having been born in Scotland. She was five years old and had been a student for four months under a young kindergarten teacher in a Winnipeg school when I met her as the school nurse for the first time. I had come to the school after the Easter holidays. Roberta's problem revealed itself when I was completing a class health examination of skin and tonsils. It was the second examination for these children and the pretty young teacher told me quietly before I started that there might be an outburst from one of them. She had prepared the class for my visit and hoped everything would go smoothly.

I could see tears in Roberta's eyes and a worried look on her face as she approached me. I reassured her and she let me examine her hands and arms. When I asked if I might see her teeth, she put her hands up to her face and burst into sobs. The teacher took her to one side but no amount of coaxing would persuade Roberta that the nurse's looking was just part of a plan to make sure every boy and girl had "clean hands, teeth, and hair."

A subsequent private conference with the teacher revealed that this had been Roberta's performance when the former nurse had made an appearance. Further, whenever the teacher had given simple talks on health habits to her class, she had

received stiff, formal notes from Roberta's mother saying that "her daughter's health was her responsibility and not the teacher's. Would she mind teaching her child something constructive, instead of just having her play on paper?"

The teacher had invited Roberta's mother to pay her a visit but she had only visited the principal who had tried to explain the program carried on by the kindergarten teacher. There still seemed to be questions and conflicts unanswered which were not healthful for Roberta's own mental hygiene in her family set-up. Consequently, the nurse agreed to make a home visit to gain more understanding for herself and the teacher.

The first visit was helpful in revealing Roberta's mother as a middle-aged Scottish lady of good intelligence who had been twice married. She had one son Richard, 12 years old, by her first husband who had been killed in the raid on Dieppe. She had been very happy in her first marriage and Richard seemed to be getting along well in school. Roberta was the daughter by her second husband, a Canadian soldier a few years younger than his wife, whom she had met and married a year after the death of her first husband. She had had many expectations when her husband suggested they return to his home in Winnipeg, following his discharge from the army. I gathered they had not all been fulfilled. The uncertainty of her husband's job with a meat-packing plant, the monthly payments to be made on a new home, the difficulty she was having in making friends in a new country, and the

Miss Marshall is a staff nurse with the Winnipeg Health Department.

differences in the schooling of Canada and Scotland were causing conflicts that would affect anyone with her rather dour Scottish outlook. I did very little more than listen at the first visit but I did try to interpret the teacher's and the school nurse's role with her child. When I left after the visit the mother extended me a cordial invitation to call again.

The difference in early school training between Scotland and Canada accounted for a lot of misunderstanding in the work Roberta was taking home to her mother. I felt the mother had only a fair appreciation of the fact that Roberta needed approval of her "little bits of work." She was also jealous of her daughter's affection for the kindergarten teacher. The incident at the class health examination had occurred because of the conflicts that were being built up inside Roberta whenever her mother would voice in strong terms what she thought about the health talks that were given to her in school by the teacher and the nurse.

Through teacher-nurse conferences, we gained more insight into Roberta's problem. Together we planned, along with several of the nurse's visits to the home, how we could make Roberta's mother more aware of her daughter's needs and what the Canadian school system offers to each child. The teacher now receives cordial notes from the mother, the nurse is considered a family counsellor, and Roberta is on the road to happier mental health.

For me, Roberta's problem had crystallized how the teacher and nurse can work together for the betterment of each school child. This team was the theme of a talk I had the opportunity to give before a summer training group of kindergarten teachers. My material was gleaned from current school health books, nursing journals, child health literature, and suggestions from nurses and teachers who had been longer in the field. I found that my discussion was enriched by additions from my audience—sometimes a difference of opinion, sometimes a helpful, prac-

tical suggestion. One quarter of the teaching group came from rural points and I had to temper my statements to suit their needs. Briefly, these were the points covered under the five divisions of the discussion.

HEALTHFUL SCHOOL ENVIRONMENT

The school nurse is always present as a counsellor to guide the teacher in the most healthful use of her classroom. When the teacher has the good fortune to be asked to supervise the arrangement of fixtures in her room, it will be to her advantage to have toy cupboards built for the use of the children and clothes-lockers or hangers for their individual heights. Certain colors on walls reflect more light than others and the teacher can help to arrange children at windows when doing close work to give them the maximum amount of light. Everyone who is responsible for the safety of the child should be alert to the fact that the school environment includes the whole school, playground, parks, streets and intersections where children may travel.

RECOGNITION OF PHYSICAL AND MENTAL DISEASE

The teacher, constantly observant of her class, can be most helpful in detecting the child with an unusual physical or mental state who should be reported to the nurse. I showed the group the informative, well-illustrated booklet, published by the Metropolitan Life Insurance Company, entitled "What Teachers See." This gives pertinent descriptions of common childhood diseases and conditions. I pointed out how diseases occur by seasons among school children:

Sept.-Oct. —Signs of skin disorders.

Nov.-Dec. —Signs of cold, tonsillitis, scarlet fever, and other communicable diseases.

Jan.-Feb. —Signs of measles, whooping cough.

Mar.-Apr. —Signs of chickenpox, mumps.

May-June —Signs of skin diseases and sunburn.

This seasonal incidence would vary from district to district.

I felt that the teacher could easily be the key person to detect a child with a visual or hearing defect. Many of the kindergarten children do not have medical examinations prior to their school entrance and the mother may mask her child's defect in her care of him. The teachers contributed to my few sentences about the observation of the child with unusual symptoms of emotional tension. They all felt that each child showed varying emotional symptoms at the beginning of the term, as they were learning to give and take.

DEFINITE PROGRAM OF SCHOOL HEALTH

The health program, as with any other school plan, should be integrated into all activities—flexible, seasonal, and practical. I have found a simple plan is to work a program suitable for each month:

Sept.—First aid procedures; safety rules for school and streets; teaching of basic health habits; explanation of nurse's duties.

Oct.—Teaching in prevention of colds—i.e., use of proper amount of clothing, fish oils; importance of diet.

One of the practical suggestions for health teaching on which I commented was the daily class health inspection. I advocated it as the duty of the teacher to make some type of health inspection every day in order to screen the child with infection. For the pleasure of the children it should be varied. It is often a splendid opportunity for incidental health teaching. Many of the teachers added refreshing ideas they had gathered for these inspections, such as races and inspection of the children by one of the class who acts as nurse or doctor.

I suggested that children could be shown the value of water and sunshine through watching plants grow. Many of the teachers had used this idea successfully.

The observance of safety rules for street crossings could be the objective of a class field party to watch a street corner where a policeman was on

duty. A mock street scene could be a practical play experience in their classroom.

Health habits can be taught through discussion of the habits of the new baby or pet animal that has arrived in one of the children's homes.

I explained that it was not the duty of the nurse to supplant the teacher in her health teaching but to reinforce what she said. The nurse was usually on hand to help the teacher with additional health literature or timely posters for the particular health project that was being carried out.

TEACHER AND NURSE COOPERATING

This side of the teacher-nurse team is important enough to warrant a separate division. There are many ways in which this cooperative spirit can be built up. In order to help understand the school child and his problems, the teacher and nurse contribute those pertinent details which assist in rounding out the picture of the child in his background. The nurse is able to make her home visit with an adequate knowledge of the problems and is able to offer suggestions that have been worked out jointly with the teacher. Opportunities for frequent teacher-nurse conferences build up this cooperative spirit. Through them, the nurse reveals to the teacher the children's defects discovered at medical examinations and any limitations which these defects may place on the child. An interchange of professional literature between the teacher and the nurse gives each a better understanding of the other's work.

IMPORTANCE OF HEALTHY TEACHER

The nurse is interested, too, in the health of her teachers. They both know that the teacher who will give most abundantly to her class must be vitally healthy. All the maxims for good health are essential to the teacher plus a few special ones:

1. An adequate convalescence following illness.
2. Striving for mental relaxation in interests and hobbies that will let her

associate with those not in her professional group.

Finally, where there is a proper appreciation by the teacher and nurse of what each is trying to do, it follows that there will be a better

understanding of the school children and their needs. Individual problems, such as little Roberta's experience, have more chance of a happy solution by the cooperative work of the teacher-nurse team.

In the Good Old Days

(*The Canadian Nurse*, November 1910)

"While serious fires are not common in hospitals . . . every hospital should have a fire-drill instituted and it should be practised often enough to be well in mind. It is useless to include in this drill the average servant, who comes and goes with such regularity, but it should take in the engineers or night-watchmen (who are apt to be more or less permanent) and the nurses. Some institutions have used, instead of the regulation drill, a lesson to be learned verbatim and recited as often as once a month."

* * *

"A very large number of the mistakes which nurses make are the result of their having been insufficiently taught. It seems axiomatic that a nurse should not be allowed to do a thing unless she knows how; yet over and over we permit accidents to happen from the violation of this principle . . . We excuse ourselves for these occurrences by the plea that we are short of nurses and lack the time to give instruction. This is a chronic state of affairs in most hospitals."

* * *

"An impressive service in commemoration of the late Florence Nightingale, O.M., (who died on August 13, 1910), was held in St. Paul's Anglican Church, Toronto."

* * *

"*The Canadian Nurse* Editorial Board is now an incorporated body . . . This step places us in a better position to properly and regularly carry on the work incidental to the publication of *The Canadian Nurse*—that magazine which has come to mean so much to the nurses of Canada and to which the nurses of Canada are so loyal."

* * *

"We congratulate our friends at Edmonton on the coming Alexandra Hospital, the erection of which is now proceeding in the city."

"When I first made known to my friends the fact that I intended taking a post-graduate course, they held up their hands in horror. Wild tales were poured into my ears of the awful things that were said and done to a post-graduate nurse . . . From what I have seen I think that in most cases the bad treatment a post-graduate nurse receives is due to her own actions . . . I have heard several post-graduates complain of the way they were treated by pupil nurses but in almost every case the post-graduate nurse was in the wrong . . . The post-graduate nurse is subject to the same rules as the pupil nurses, while graduates of the school are allowed several privileges as to late leave, laundry, etc."

* * *

"In its war on tuberculosis, New York City has organized a 'day camp' that is at present located on an unused ferry boat. Despite its name, adult male patients are allowed to stay there at night as well as during the day, sleeping on cots on the upper deck in the open air. The women and children are admitted during the day. As tubercular children are now debarred from New York schools, a regular public school is conducted on board the boat. In addition to the regular studies, the pupils have special lessons in hygiene, cleanliness, diet, breathing, etc."

Tolerance means we should not expect too much of other people. One of the commonest mistakes is expecting people to be reasonable. Yet few, if any, people will always be reasonable from our standpoint. To put it another way, our viewpoint will not always seem reasonable to other people. We will save ourselves many disappointments if we *do not expect people to be reasonable*.

—K. C. INGRAM

Aux Infirmières Canadiennes-Françaises

Service Social à l'Ecole des Infirmières

GENEVIÈVE LAMARRE

Average reading time—11 min. 12 sec.

C'est d'une idée nouvelle que je veux vous entretenir, idée que des circonstances particulières m'ont suscitée et qu'une expérience, assez récente d'ailleurs, m'a permis d'apprécier. Il s'agit du Service Social à l'École des Infirmières.

On a défini le Service Social: l'art d'adapter l'individu à son milieu et le milieu à l'individu.

La transplantation subite de l'étudiante au milieu hospitalier est un fait. Les problèmes que cette transplantation même soulève sont connus de chacune de nous, étudiantes d'hier, et particulièrement du personnel de l'école, témoin quotidien des situations de l'étudiante infirmière.

Quels sont ces problèmes? D'adaptation d'abord.

Adaptation à l'école: Milieu nouveau où l'étudiante rencontre un mode de vie qui ressemble vaguement à celui du pensionnat: horaire, vie en commun, cours, etc.

Adaptation aux compagnes: Passe encore pour le contact avec le groupe des probantes dont elle est. Mais il y a les aînées, élèves de 2^{ème} et 3^{ème} année, qui volent déjà de leurs ailes et que l'activité journalière tient un peu éloignées d'elle. Pour les comprendre, se les expliquer, il faudra le temps—ce grand maître. Mais entre temps, que d'étonnement, d'interrogations! Un commun idéal a rassemblé les autres depuis quelque temps déjà, mais peut-on dire qu'une affinité de caractère les unit invariablement?

Adaptation à l'hôpital: Cet édifice,

ces longs corridors, ces portes mi-closes d'où s'échappent ronrons, souffles, soupirs, et plaintes; ce va-et-vient, tous ces uniformes et costumes divers: l'officière, l'infirmière, l'étudiante, le médecin, l'étudiant, l'infirmier, les aides, les employés de service, les visiteurs—tous ces gens passent.

Et les choses qui passent aussi: civières, chariots, chars à pansement, odeurs...

Adaptation aux patients: Ces gens qui souffrent, ceux que la maladie retient, ceux qui circulent. Et lorsque l'étudiante a bien ouvert les yeux, pris contact avec le souffrant; il vient l'adaptation à la souffrance, la compréhension du malade, de ses besoins, et de ses états d'âme.

Adaptation au personnel: Du côté de l'école, du côté de l'hôpital. Que de relations subites et variées, mais pas nécessairement toutes faciles et heureuses.

Adaptation à elle-même: Hier libre, aujourd'hui consacrée, "marquée d'un signe spécial, celui de dévouement. Hier jeune fille, aujourd'hui messagère de santé, d'espoir de guérison. Eduquée et éducatrice, apôtre de paix sociale, agent de liaison charitable entre les libéralités et les détresses."

Quels sont encore ces problèmes auxquels se heurte l'étudiante infirmière? Ce sont les difficultés inhérentes à notre lot humain. Elles sont:

D'ordre personnel: Bien intimes, ces difficultés originent d'abord du fait de sa vocation, de ses responsabilités nouvelles. Puis il reste toujours "le vieil homme," les conflits personnels, les conflits émotifs, sentimentaux, les forces qui cèdent.

Mlle Lamarre est directrice des études, l'Hôpital de l'Enfant-Jésus, Cité de Québec.

D'ordre familial: Transplantation disions-nous au début, mais plutôt bonté ou mieux marcotté. Le rameau tient encore à la branche-mère. Épreuves et joies familiales, sources de réactions chez l'infirmière.

D'ordre économique: Quelles sont la plupart du temps les ressources de l'étudiante? Elles sont le reflet de la condition sociale et familiale de la région, souvent précaires.

D'ordre social: Rupture ou quasi rupture avec le cercle coutumier. Ajustement, ré-éducation, adaptation à des relations nouvelles.

D'ordre professionnel: Au début de l'entraînement, les appréhensions; durant l'entraînement, la nécessité d'allier la formation scientifique, l'habileté technique, les obligations morales; puis, le problème à répétition de l'orientation: notre étudiante sera infirmière.

Voilà résumés les problèmes divers qu'affronte l'étudiante en son milieu scolaire. N'est-ce pas assez pour vérifier la nécessité d'un Service Social où l'on tient compte de son essence même: adapter l'individu à son milieu et vice-versa? Nous lançons l'idée, sans crainte des retentissements, assurée que nous sommes, que le bien ne fait pas de bruit.

Nous ne tenterons pas de préciser les cadres; ce serait vraiment trop ronflant pour 1950. Nous bornerons à un exposé simple de ce qu'il nous a été donné de réaliser. La travailleuse sociale, comme l'infirmière, réalise quotidiennement sa vocation. Elles ont certainement un but commun: le service à autrui.

Appelée à la direction des cours d'une école de gardes-malades, comme infirmière, nous ne nous sommes pas départie de notre formation de travailleuse sociale. Le prochain nous presse encore. Les problèmes se sont présentés aux étudiantes et les étudiantes à nous.

Sans affichage, nous avons reçu les élèves, nous avons utilisé nos techniques générales, du Service Social, en les adaptant. Nous les avons associées aux méthodes d'éducation.

Il n'a jamais été question d'heure fixe pour les entrevues. Le travail

s'est souvent révélé fructueux à cause de la facilité de connaître le problème et le milieu: le problème et le milieu nous étant très familiers. Nous n'avons eu par ailleurs, aucun mérite à établir nos contacts; la compréhension de nos collaboratrices ne nous a pas été accordée sous le titre officiel de Service Social: l'esprit seul y présidait.

Pour illustrer le travail que nous avons tenté de réaliser, nous mentionnerons une ou deux histoires de cas.

Mlle V., élève de 1ère année, rate un test. Nous lui imposons la reprise. Elle accepte bien mais nous laisse voir un peu de panique devant cet échec scolaire. Le lendemain, lors d'une rencontre, elle veut parler sa gorge s'étrangle—"Je ne suis pas intelligente. Je ne fais rien de bien. Ça ne va pas non plus au département." Cette jeune étudiante, grande, pâle, jolie, à l'expression un peu triste, mais pure, nous raconte qu'elle développe un complexe d'infériorité depuis l'âge de huit ans, alors qu'elle reprit la classe après une absence due à une pneumonie. L'institutrice d'alors lui reprochait de n'être plus intelligente parce qu'elle ne rattrapait pas le rang qu'elle tenait avant la maladie. La mère, de son côté, lui faisait souvent la remarque qu'elle n'était plus aussi intelligente qu'à l'âge de sept ans.

Au département, elle redoute la surveillance, tant elle s'imagine inférieure et de fait les gaffes se multiplient. Elle pleure, cyanose, ne peut plus retourner aux soins des malades, ne peut s'expliquer avec son officière. Nous l'assurons que sa mesure intellectuelle n'est pas donnée. Nous lui soulignons sa faiblesse nerveuse, lui recommandons de voir un médecin et d'aller exposer son cas à la directrice de l'école qui est, en somme, la mère spirituelle des élèves. Elle s'oppose, avouant la crainte, nous lui proposons de se reposer au lit. Nous faisons de l'air, couvrons l'élève, et l'assurons que nous irons l'éveiller. Pendant le repos, nous exposons le cas à la directrice et suggérons le transfèrement de l'élève du département des dames à celui des messieurs où le service est moins harassant et l'officière d'approche moins sévère. L'élève demande une entrevue

à la directrice qui lui permet de s'extérioriser, de se raconter. Le transfèrement lui est proposé pour équilibrer ses forces; elle suit un traitement. L'élève nous rencontre ravie, souriante, étonnée d'avoir été comprise. Ses succès scolaires se succèdent. Chez les malades, ses soins sont bien évalués; sa nervosité disparaît, son visage est détendu. Chaque fois que nous la rencontrons elle sait sourire et dire sa reconnaissance. Il y a deux jours, elle nous avouait avoir échappé à l'envie folle de partir.

Mlle B., 3ème année, distinguée belle éducation, situation aisée, brillante élève. Infirmière douée dont le perfectionnement pourrait enrichir notre groupe et notre société. Nous causons de spécialisation. Elle se montre piquée, vient régulièrement pour choisir son domaine avec nous. Finalement nous l'orientons en éducation aux Etats-Unis.

De combien d'exemples encore, nous pourrions illustrer notre causerie. Mais le fait est là. Nous recevons les données; faisons l'histoire sociale, posons le diagnostic pour

aborder le traitement.

Faut-il avouer la satisfaction qui en résulte; nous ne parlerons pas de celle de l'élève, mais nous ressentons la nôtre.

Une ombre se pose—c'est le manque de temps, cancer social!

Pour une réalisation fructueuse, nous envisageons pour le moment l'organisation du Service Social aux mains de la directrice des cours qualifiés comme l'étude du problème et du milieu.

Nous envisageons aussi la possibilité du succès, dans une répartition de sa tâche de directrice d'études; division du travail scolaire, par la collaboration d'institutrices spécialisées.

Cette innovation nous tient à cœur comme moyen indispensable d'éducation, de cette éducation dont Spalding a dit qu'elle est le développement complet de toutes les forces humaines—forces naturelles, surnaturelles, sociales, vitales, personnelles, et professionnelles.

The Menopause

The menopause occurs in both sexes. It is a means of preservation. In the female the alteration takes place comparatively rapidly; cessation of menstruation is the striking change. The purpose of the menopause is to end the possibility of reproduction, since pregnancy and labor would expose aging tissues to severe physical risks. As usual, a good margin of safety is provided so that 20 to 30 years remain before dissolution ends her usefulness to the youngest possible offspring. In the male, the problem of reproduction incurs no similar risks. Spermatogenesis, therefore, continues, slowly diminishing with age. The associated changes are also gradual and the menopause in the male, though definite, is less impressive—with very rare exceptions.

The lack of "growth hormones" at this

time, rather than any change in the vascular supply, probably produces the rapid form of osteoarthritis (and bursitis), with the appearance of painful Heberden's nodes which occur in women. This process has nothing to do with infection or foci of infection. After a temporary disability this affection dies down as osteoarthritis always does and the treatment is on normal lines. Reduction in weight is the most beneficial. In the male quite similar regressive joint changes appear, probably from the diminishing supply of "growth hormones" but, like lessening spermatogenesis, it is a gradual, milder process, without any sudden transformation which, in the female, has earned it the name of "menopausal arthritis."

—TREVOR OWEN, M.B.

Welfare in Ontario

Approximately 23,000 persons now receive relief in Ontario municipalities and unorganized areas in northern Ontario. This group comprises persons who are mainly ineligible for special forms of assistance such

as Old Age Pensions, Mothers' Allowances, etc. Physical disabilities are mainly the reasons for the majority of persons receiving relief at this time. Other major causes include separation and desertion cases.

Nursing Profiles

Another of Canada's outstanding nurses has retired. **Kathleen W. Ellis** relinquished the last of her professional responsibilities this summer and has settled down in her own home town of Penticton, B.C. Miss Ellis reports that she becomes more intrigued each day with the intricacies of housekeeping. Those of us who know her well will understand how thrilled she was to find that her neighbors love a game of bridge. Miss Ellis asked us to extend a cordial invitation to the members of our profession "to visit my home where there will always be a warm welcome and a lovely view, soul-satisfying, if not much else. My garden includes two peach, three pear and a huge apple tree, so no one starves in fruit season and pickers will be especially welcome!"

Of Irish parentage, Miss Ellis journeyed to Havergal College, Toronto, for her high school education. She went further afield for her professional education, graduating from Johns Hopkins Hospital, Baltimore, in 1915. Service with the C.A.M.C. called her soon after. For over a year Miss Ellis was matron of the Vancouver Island Military Hospital. She returned to Johns Hopkins briefly as

second assistant in the school of nursing office. Operating room supervisor at the Henry Ford Hospital, Detroit, and second assistant in the school of nursing office at the Toronto General Hospital were the prelude to her assumption of the heavy duties of superintendent of nurses and director of nursing service at the Vancouver General Hospital.

Following her resignation in 1929, Miss Ellis decided to sample public health nursing. She enrolled at Bedford College, University of London, and received her certificate in 1930. The drawing power of hospital administration was strong, however, and upon her return to Canada Miss Ellis accepted the position of director of nursing at the Winnipeg General Hospital. She resigned five years later and returned to university work, securing her B.S. degree from Teachers College, New York, in 1937.

Her interest in professional organization work took a very practical form when Miss Ellis assumed her duties with the Saskatchewan Registered Nurses' Association as secretary-treasurer, registrar, and adviser to schools of nursing. Under her energetic leadership, the interests of nursing education advanced rapidly in that province, culminating in the organization of the School of Nursing in the University of Saskatchewan. Miss Ellis herself assumed the directorship of this school with the rank of professor of nursing. She has retired simultaneously from the association and the university work.

The strains on the fabric of nursing which were wrought by World War II necessitated the appointment of an emergency nursing adviser at our National Office. Miss Ellis was the unanimous selection of the Canadian Nurses' Association to fill this difficult role. Eighteen months later, she assumed the full responsibility of general secretary of the C.N.A., as well as national adviser, for one year. In the fall of 1944 she returned to Saskatchewan.

As she settles down to her less strenuous life, Miss Ellis carries the hearty good wishes of nurses everywhere that she will long enjoy her happy relaxation. That she will be missed is inevitable. Perhaps she will favor us with



Notman, Montreal

KATHLEEN W. ELLIS

periodic appearances at conventions where we can enjoy again both her broad understanding of nursing problems and her exotic nats.

Ruth Catherine Aikin has assumed her new duties as assistant secretary-registrar with the Association of Nurses of the Province of Quebec. Born in Prince Albert, Miss Aikin received her education in Winnipeg and Westmount, Que. She graduated from the Montreal General Hospital in 1938. General staff and private nursing provided useful background experience prior to her entry into the field of industrial nursing with Canadian Car Munitions Ltd., in 1941. Three years later Miss Aikin enlisted with the R.C.A.M.C. and served in Canada before proceeding to England with No. 11 C.G.H.

A desire to broaden her educational background led Miss Aikin to McGill University following her discharge from the services. She received her B.A. in 1948 and her B.N. in 1949. For the past year she has been an instructor at the Montreal General Hospital. Her active, interested, and pleasant personality and incisive mind will add new strength to this busy association.



Van Dyck, Montreal

R. CATHERINE AIKIN

Margaret Murray Campbell, who is assistant director of public health nursing with the B.C. Department of Health and Welfare, was born in Prince Rupert of Scottish parentage. Educated in Vancouver, she graduated from the Vancouver General Hospital in 1941 and received her B.A.Sc. from the University of B.C. in 1942, majoring

in public health nursing. In 1949 Miss Campbell received her M.P.H. from the University of Michigan where she was elected to the Phi Kappa Phi Honor Society for her high scholastic standing.

Miss Campbell started out as a staff nurse with the public health service in the Matsqui-Sumas-Abbotsford area in B.C. in 1942. Four years later she became senior public health nurse in Kamloops district, being appointed supervisor in that territory the following year. She moved up to become a supervisor from the central office in Victoria in 1948 and assumed her present position in September, 1949.

Committee work in the R.N.A.B.C. has given Miss Campbell an insight into the many problems that confront professional nursing today. She is a member of the Alpha Omicron Pi Alumnae and of the Soroptimist Club of Victoria. She relaxes at golf and handicrafts and includes care of gold-fish among her hobbies.



Campbell Studio, Victoria

MARGARET CAMPBELL

Isabelle MacLean Reesor has joined the faculty of the School of Nursing of the University of Alberta this autumn after having completed requirements for her master's degree at Teachers College. She is lecturer in public health nursing. A graduate of the University Hospital, Edmonton, Miss Reesor received her B.Sc. in 1942 and joined the staff of the Calgary Health Department. She was the recipient of a Kellogg Fellowship this year which enabled her to make a broad study of public health nursing organization and function. Miss Reesor has maintained her earlier interest in work among teen-age girls. Riding is her favorite pastime.

Evelyn Beulah Moulton who received her B.N.Sc. degree from Queen's University, Kingston, in the spring of 1950, has joined the staff of the School of Nursing there as lecturer in nursing education. Miss Moulton graduated in 1938 from the Ontario Hospital, Kingston, after one year of affiliation with the Toronto General Hospital. In 1945, she received her certificate in teaching and supervision from the University of Toronto School of Nursing and has been active both as an instructor and a supervisor in her own school. Very versatile, Miss Moulton has a wide variety of hobbies, including reading, needlework, cooking, gardening, cycling, and riding. She is keenly interested in church work.



Ashley & Crippen, Toronto

EVELYN MOULTON

Winifred Norquay has taken up her duties as nursing service consultant with the Alberta Tuberculosis Association. A graduate in 1936 of the Royal Alexandra Hospital, Edmonton, Mrs. Norquay engaged in general duty for a couple of years before becoming assistant in charge of the obstetrical unit at R.A.H. During the five years she was associated with this department, she took time out for post-graduate work in obstetrics and gynecology at the Chicago Lying-In Hospital. In 1945, Mrs. Norquay switched to industrial nursing and personnel work with the Great Western Garment Co. in Edmonton. Four years later she enrolled in the course in public health nursing at the University of Alberta. Following graduation there, she took a special course at the Central Alberta Sanatorium, Calgary, in preparation for her new duties. Mrs. Norquay has always been active in her alumnae association and

for relaxation turns to golf, riding, and bowling. Her new work will take her to all parts of the province.



Kensit Studio, Edmonton

WINIFRED NORQUAY

Five new supervisors have recently been appointed to as many health units with the Ontario Department of Health. **Helen Elizabeth Etherington**, a graduate of the St. Catharines General Hospital in 1938, who took her certificate in public health nursing in 1942 and in administration and supervision in 1947 from the University of Toronto School of Nursing, is supervisor with the Muskoka District Health Unit. Miss Etherington has worked in tuberculosis sanatoria and has had public health nursing experience with the Toronto Department of Public Health, International Nickel Co., in Chilliwack and Prince Rupert, B.C. She had had three years' experience as a health unit supervisor. Saskatchewan-born **Carrie B. Genik** graduated from the Royal Alexandra Hospital in Edmonton and received her public health instruction in both the basic and senior levels at the University of Toronto School of Nursing. Now supervisor of public health nursing in the Kenora-Keewatin area health unit, Miss Genik has worked in the Niagara Peninsula Sanatorium, as staff nurse with the St. Catharines-Lincoln health unit, and as senior nurse with the Northumberland-Durham health unit in Cobourg, Ont. **Grace Inglis Joyce**, born in Scotland, graduated from Cumberland Infirmary, Carlisle, Eng. She received her basic

public health training at Wayne University, Detroit, the advanced at University of Toronto. Mrs. Joyce had varied nursing experience in the United Kingdom before her marriage. In 1946 she joined the Health Department staff in Windsor where she is now supervisor. **Miriam C. MacDonald** is supervisor of the nursing division with the Prince Edward County Health Unit. A graduate in 1938 of Toronto Western Hospital, Miss MacDonald holds both basic and advanced public health nursing certificates from the University of Toronto School of Nursing. After four years on the staff of the Toronto Department of Public Health, two years in North Bay as senior nurse, and a year in supervisory work at Windsor, Miss MacDonald will now have an opportunity to work in the rural service which she prefers.

A. Mary Pae, who graduated from the Montreal General Hospital in 1937, also received her public health certificates from the University of Toronto. Miss Pae had wide experience in hospital work before enlisting with the R.C.A.M.C. in 1942. She served three years overseas in England and on the Continent. She had worked in the Brant County health unit before moving up to her present position as supervisor with the Lennox and Addington County unit in Napanee.



MARY E. INGHAM

Mary Elizabeth Ingham is the superintendent of nurses at Victoria Public Hospital, Fredericton. Born and educated in Toronto, Miss Ingham graduated from the Hospital for Sick Children and later secured her certificate in teaching and supervision in schools of nursing from the McGill School for Graduate Nurses. She has had wide experience in institutional work, including head nurse of

a surgical ward, operating supervisor, and instructor in her own school; second assistant superintendent of nurses and clinical supervisor at Toronto General Hospital; superintendent of nurses at the Moose Jaw General Hospital; and superintendent of the L. P. Fisher Memorial Hospital in Woodstock, N.B.

Julia Helena Barbara Ryfa has been appointed superintendent of nurses of the Brandon Mental Hospital where she graduated five years ago. Miss Ryfa recently completed a course in supervision in psychiatric nursing at the McGill School for Graduate Nurses. Outside the professional sphere, Miss Ryfa's chief joy is ballet. She plans to start a collection of recordings of ballet and classical music. Bowling and leathercraft supply her with interesting hobbies.



JULIA RYFA

Dorothy Hibbert is now assistant superintendent of nurses of the Winnipeg General Hospital. Born and educated in Boissevain, Man., Miss Hibbert graduated from W.G.H. in 1937. She received her certificate in teaching and supervision from the University of Manitoba School of Nursing in 1944. For nine years Miss Hibbert served as head nurse on several surgical wards at W.G.H. and for two years has been clinical supervisor in surgical nursing. She was a member of the provincial R.N. examination committee for four years and is currently a member of the Board of Directors of the M.A.R.N. She turns to handicrafts for her leisure-time activities, including petit point, glove making, etc.

Anne Catherine Munro, who graduated from the Winnipeg General Hospital in 1919, has had a rich and full life in her work in India under the Canadian Baptist Foreign Mission Board. In addition to her medical



Courtesy Winnipeg Tribune

ANNE C. MUNRO

and evangelistic service, Miss Munro has translated the Scriptures into the language of the Saora Hills tribe. She was the recipient of the Kaiser I Hind Medal in 1946 for distinguished humanitarian service with special reference to Saora language research. Miss Munro has the unique distinction of being a member of the Legislative Assembly of Orissa. She was nominated to this important office by the governor to represent the scheduled castes and tribes of Parlakimedi Agency of Ganjam.

Esther Mary Beith, who retired in August after fulfilling 25 years as executive director of the Child Health Association of Montreal, is one of those rare persons who was able to combine the scientific approach required in modern health practices with spontaneous sympathy and understanding. Thus she has built up a strong and active organization, providing a much needed service for the children of Montreal. At the same time her sound judgment, her vision of future possibilities in health services, and her ability to rapidly and effectively assess current problems has resulted in her advice being sought by welfare authorities far beyond the limits of

her own agency in Montreal.

Miss Beith graduated from the Hospital for Sick Children, Toronto, in 1914. For nine years she was on the staff of the Toronto Department of Public Health, during which time she assisted as a part-time lecturer in the newly established School of Nursing at the University of Toronto. She was superintendent for a year at the Dalhousie University Clinic in Halifax before beginning her work in Montreal. The McGill School for Graduate Nurses benefitted by her services as a part-time lecturer for nine years. Professional nursing, too, has been the richer for the work and guidance which Miss Beith offered through the various associations. Her greatest reward was always to see how well her protégées progressed.

In preparation for her retirement, Miss Beith had built a cottage at Herring Cove on the Nova Scotian coast near Halifax. Here, her living-room windows look out over the sea that she loves. Long years of happiness to you, Esther Beith!



ESTHER BEITH

Beatrice E. Williams, who for the past 26 years has been on the staff of Ste. Anne de Bellevue D.V.A. Hospital, has retired. Miss Williams is a veteran of World War I. She enlisted in 1916 and served overseas in England and France until 1919. The staff honored Miss Williams on her retirement with a tea at which they presented her with a beautiful table lamp.

Hope springs eternal in the human breast
but a wishbone never took the place of a
backbone!

Trends in Nursing

Average reading time — 4 min. 48 sec.

THE PAST SEVERAL ISSUES of the *Journal* have pieced out the picture of the 25th biennial convention with fairly full coverage of the papers presented, the work conference reports, and the general picture of events. There remain still to be recorded here the resolutions that were unanimously adopted and, as a final wind-up, the lists of the members appointed to act on the various committees. It is hoped that all of the acceptances to act will have been received in time to permit us to publish these lists on this page next month. The resolutions and recommendations were presented to the last session of the convention.

Work Conferences

Following the presentation of the summaries of the work conferences, the president, Miss Cryderman, suggested that possibly the time has come when work conferences should be considered on the regional and provincial rather than the national level. This proposal was endorsed by Miss Marion Myers in her brief words of thanks to the various consultants. We shall hope to see a much wider development of this educational pattern than has heretofore been practised. National Office is always delighted to receive requests for assistance in the organization of such programs. The provincial association headquarters staffs are also well equipped with information on how to organize work conferences locally. What can you plan in your own community?

Resolutions

National emergency: In reporting on the registrars' informal discussion of international affairs, Miss Lillian Pettigrew explained that there was no thought of casting a shadow of gloom over the convention by the

introduction of a resolution pointing to any possible national emergency, but rather it was intended that some consolidation of thinking would precipitate a readiness to assume the responsibilities of the Canadian Nurses' Association if such a situation should arise. The following resolution was unanimously adopted by a standing vote accompanied by the applause of the members:

WHEREAS, Recent developments in international relationships suggest the possibility of a national emergency arising; and

WHEREAS, In such an event nursing services would be of major importance; and

WHEREAS, The Canadian Nurses' Association, representing more than 30,000 registered nurses, would be able to assist in any needed mobilization of nursing services; therefore be it

Resolved, That, in the event of a national emergency, the President be authorized to call immediately a special meeting of the full Executive Committee of the Canadian Nurses' Association to plan and initiate appropriate action.

The report of the Resolutions Committee was read by Miss Rae Chittick. The first resolution dealt with the problem of *financial support for schools of nursing:*

WHEREAS, The cost of operating schools of nursing is not known at the present time; and

WHEREAS, The first step to take before making any approaches for financial assistance is to know the cost of educating student nurses; therefore be it

Resolved, That Provincial Associations be advised to approach their Health Departments to ascertain the formula to be followed in satisfactorily separating school of nursing and hospital costs and to urge that Federal Grant money be allocated for support of schools of nursing and, moreover,

That hospital schools be encouraged to take immediate steps to separate such costs and, further, that hospital schools

submit definite projects for assistance through the Federal Health Grants to their provincial Health Departments. When the time seems opportune the Canadian Nurses' Association should again request the Federal Government to consider the possibility of making direct grants to nursing education. In making such an appeal the Canadian Nurses' Association should endeavor to gain the support of the Canadian Hospital Council and the Canadian Medical Association.

It was pointed out that, in approving this resolution, the general membership had agreed that such action should not nullify former resolutions with respect to approaches to governments for financial support for nursing education.

* * *

WHEREAS, The General Interest Sessions have proven both interesting and profitable in keeping nurses in touch with newer nursing procedures; therefore be it

Resolved, That such General Interest Sessions, particularly the Neurological Nursing Demonstration, be incorporated into the program of the next biennial meeting.

* * *

Two resolutions had grown out of the general session of the Public Health Nursing Committee. These were presented to the convention for endorsement by the membership of

the Canadian Nurses' Association:

WHEREAS, The Public Health Nursing Committee of the Canadian Nurses' Association endorses the report of the Study Committee on Public Health Practice in Canada; and

WHEREAS, It is felt that this important study should receive the serious consideration of all nurses engaged in both service and education; therefore be it

Resolved, That the Public Health Nursing Committee of the Canadian Nurses' Association join the Public Health Nursing Section of the Canadian Public Health Association in an endeavor to stimulate interest in the study of the report on the local, provincial, and national levels with a view to implementation of the findings in as far as is possible.

* * *

WHEREAS, The Public Health Nursing Committee of the Canadian Nurses' Association supports the recommendation of the report of the Study Committee on Public Health Practice in Canada "that a study be made of methods of preparing nurses so that they may be more fully qualified to contribute to the community health services"; therefore be it

Resolved, That this matter be referred to the Educational Policy Committee of the Canadian Nurses' Association and to the Council of the University Schools and Departments of Nursing for action.

Orientation et Tendances en Nursing

Les derniers numéros du *Journal* contenaient les activités du 25e congrès biennal, les travaux présentés, les rapports des foyers d'étude, et un aperçu général des événements.

Il reste à vous faire part des résolutions adoptées et, en finale, à vous donner la liste des membres appelés à siéger sur les divers comités. Nous espérons que les membres de ces comités donneront leur réponse d'ici au mois prochain et que nous serons alors en mesure de publier cette liste. Dans ces colonnes, nous vous présentons les résolutions et les recommandations faites à ce congrès.

FOYERS D'ETUDE

Après la présentation des rapports des foyers d'étude, la présidente, Mlle Cryderman, suggéra que le temps était peut être venu de considérer l'organisation de foyers d'étude comme une activité provinciale plutôt que nationale. Mlle Myers approuva cette suggestion et remercia les consultants des foyers d'étude. Il est à espérer que cette méthode d'étude se diffusera plus que par le passé. Le secrétariat de l'Association des Infirmières du Canada est toujours heureux de répondre aux demandes qui lui sont faites pour l'or-

ganisation d'un tel programme. Les associations provinciales sont aussi en mesure d'aider. Que pouvez-vous organiser dans ce sens dans votre district?

* * *

En présentant le rapport d'une discussion entre les registraires sur les relations internationales, Mlle L. Pettigrew expliqua qu'elle ne voulait pas jeter une ombre au tableau en proposant une résolution concernant l'état d'urgence du pays mais plutôt présenter une idée pratique permettant à l'A.I.C. d'assumer toutes ses responsabilités dans une situation d'urgence.

La résolution suivante fut adoptée à l'unanimité, aux applaudissements de l'assemblée:

"CONSIDÉRANT, Que le développement des relations internationales peuvent amener un état d'urgence au pays; et

CONSIDÉRANT, Que dans un état d'urgence les services des infirmières deviendront d'une importance primordiale; et

CONSIDÉRANT, Que l'A.I.C., représentant plus de 30,000 infirmières enregistrées, serait en mesure d'aider en cas de mobilisation des services des infirmières; il est donc

Résolu, Qu'en cas d'état d'urgence du pays, la présidente soit autorisée à convoquer immédiatement une réunion spéciale du Conseil de l'A.I.C. afin de déterminer les plans à adopter et la conduite à tenir."

Le rapport du Comité des Résolutions fut présenté par Mlle R. Chittick. La première résolution concerne l'aide financière aux écoles d'infirmières:

"CONSIDÉRANT, Que le coût de revient d'une école d'infirmières n'est pas actuellement connu; et

CONSIDÉRANT, Que la première chose à faire, avant de demander une aide pécuniaire, est de connaître le coût de l'éducation de l'étudiante infirmière; il est donc

Résolu, Que chaque association provinciale se mette en rapport avec leur Ministère de la Santé respectif afin de connaître la meilleure méthode à suivre pour établir une comptabilité, séparant le coût de l'école d'infirmière et celui de l'hôpital, et d'insister auprès d'eux pour que des octrois, provenant des Octrois Fédéraux, soient accordés aux écoles d'infirmières; en plus, que l'on encourage les hôpitaux à prendre les mesures nécessaires pour établir le prix de revient de l'école d'infirmière et de l'hôpital et que chaque école d'infirmière soumette à leur Ministère de la Santé les projets définis pour lesquels ils ont besoin d'assistance."

En temps opportun, l'A.I.C. fera de nouveau des demandes auprès du Gouvernement Fédéral afin d'obtenir que des octrois soient versés directement aux écoles d'infirmières; dans ce cas l'A.I.C. demandera de nouveau appui du Conseil des Hôpitaux canadiens et de l'Association canadienne des Médecins.

Il est à remarquer, qu'en appuyant cette résolution, que la résolution semblable, préalablement adoptée par les membres, n'est pas annulée, à savoir:

"Que des démarches soient faites auprès du gouvernement pour obtenir une aide financière pour l'éducation des infirmières."

* * *

"CONSIDÉRANT, Que les séances d'intérêt général ont été à la fois d'un grand intérêt et d'un grand bénéfice pour les infirmières, leur permettant ainsi de se tenir au courant des nouvelles techniques concernant le soin des malades; il est donc

Résolu, Que ces séances d'intérêt général, particulièrement les démonstrations données par l'Institut Neurologique, soient au programme du prochain congrès biennal."

* * *

A la suite de la réunion du Comité de l'Hygiène Publique deux résolutions furent formulées et présentées aux membres du congrès afin d'obtenir leur approbation:

"CONSIDÉRANT, Que le Comité de l'Hygiène Publique de l'A.I.C. approuve le rapport du Comité d'Étude sur l'hygiène publique au Canada; et

CONSIDÉRANT, Qu'il est très important que cette étude soit portée à l'attention des infirmières travaillant à l'hygiène publique ou à l'éducation des infirmières; il est donc

Résolu, Que le Comité d'Hygiène Publique de l'A.I.C. se joigne à la Canadian Public Health Association (section du nursing) afin de stimuler, dans un effort commun, l'étude du rapport précité tant dans les milieux provinciaux que nationaux afin de donner suite aux considérations émises dans ce rapport."

* * *

"CONSIDÉRANT, Que le Comité d'Hygiène Publique de l'A.I.C. appuie la recommandation faite dans ce rapport 'd'étudier les méthodes employées dans la formation de l'infirmière afin qu'elle soit mieux préparée à remplir le rôle important qu'elle est appelée à rendre dans la société'; il est donc

Résolu, De soumettre cette question au Comité d'Éducation de l'A.I.C. et Conseil des Ecoles Universitaires et Départements du Nursing."

Corpus Luteal Hemorrhage Surgery and Nursing Care

CAROLYN F. HARVIE

Average reading time — 14 min. 24 sec.

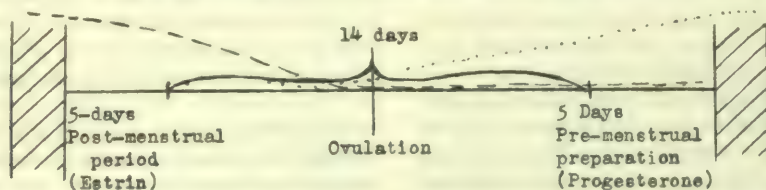
INTRODUCTION

IF QUESTIONED, most nurses' reasons for the selection of a particular patient for a case study would be, first, her interest in this patient and, secondly, her interest in the patient's disease. If the disease occurs only rarely, the case study is done because the nurse feels an urge to know why this disease is so rare, what can be done for it, and so on. If the disease is very common the student may write the report because she wishes to use the knowledge obtained in nursing the disease in future years.

Mrs. Daw's disease is particularly rare. Here was a woman who managed to look after her home, husband, and two infant children with no outside help and, although tired much of the time, kept this home running smoothly and herself in good health. Then, suddenly, she is admitted to hospital with a diagnosis of "acute abdomen—possible ectopic" and upon immediate laparotomy is discovered to have a "corpus luteal hemorrhage." What caused this to happen so suddenly and why to a woman normally appearing in the best of health?

THE MENSTRUAL CYCLE

To explain her diagnosis, I will discuss the menstrual cycle. Ovulation begins in adolescence, continues through maturity, and ceases at the menopause. Under normal conditions in the female, it proceeds smoothly and does not cause any significant symptoms. In the first two weeks of the menstrual cycle, the uterine muscle motility is greatest with the hormone, estrin, in control. Estrin is produced by the follicular stimulating hormone contained in the secretions of the anterior lobe of the pituitary gland. With the rupture of the mature Graafian follicle and the production of the corpus luteum, the uterine muscle motility is decreased under the direct influence of progesterone. Progesterone is produced by the action of the luteal stimulating hormone on the corpus luteum. It is hardly possible that the Graafian follicle can rupture without the loss of a little blood from the point of rupture or from the bed of the ovum. As a rule, it is microscopic! However, the cavity may fail to heal and severe intraabdominal bleeding occur, causing symptoms



Menstruation
(4 days app.)

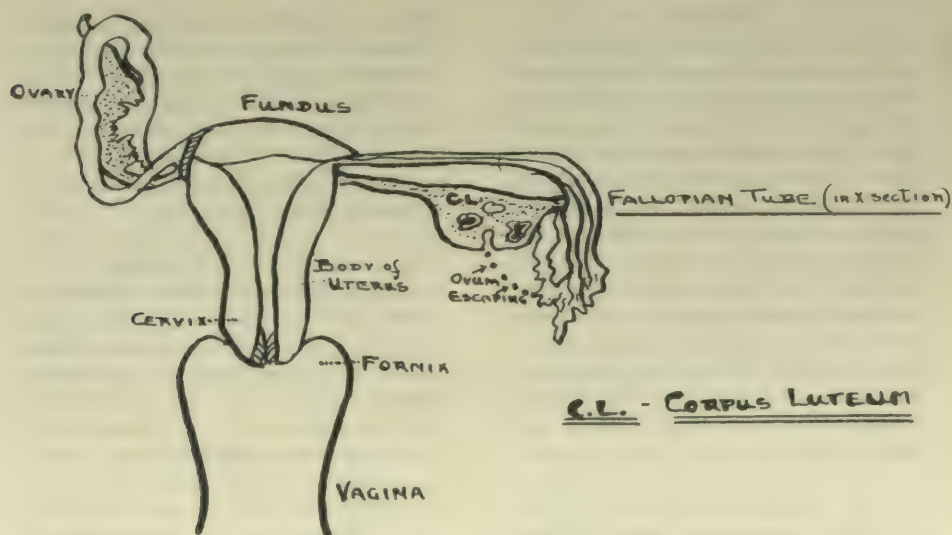
— — — — Estrin Level

..... Progesterone Level

Menstruation

Miss Harvie is a very recent graduate of the Vancouver General Hospital who prepared this study during her senior year.

much like those of a ruptured tubal pregnancy (ectopic). The menstrual cycle proceeds as per the accompanying illustration.



"Painful ovulation," under which corpus luteal hemorrhage is classified, is not common. Pain may occur between menstrual periods, regular in occurrence, and often preceding the following menstrual period by a fixed number of days. The pain is usually located in the suprapubic region, in one or both iliac fossae. Occasionally it is felt only on one side in the ovarian region. Most commonly it is located diffusely through the whole pelvis and is said to resemble dysmenorrhea. This pain is notably absent during pregnancy and lactation. There are no definite predisposing factors.

There are three clinical types of menstrual pains: First, the chronic mild type which is a classic variety referred to as "periodic intermenstrual pain." In the second type there is more severe pain which lasts longer and definitely undermines health of both the body and mind. The third type is that associated with severe intraabdominal bleeding from the ruptured ovary. Here shock dominates the picture.

Symptoms associated with these types are: dysmenorrhea, vaginal bleeding, and intraabdominal hemorrhage where symptoms also simulate a ruptured ectopic—severe abdominal pain in left lower quadrant, referred pain in right shoulder, and a pallid

complexion. Physical and palpatory findings in the third type include:

1. Leukocytosis—W.B.C. may go up to 30,000 per cu. mm.
2. The temperature rises but is usually not too high.
3. Tenderness through whole pelvis, cul-de-sac and both fornices and blood in the cul-de-sac. (This may be verified by a posterior colpotomy.)

Diagnosis is difficult with this severe intraabdominal bleeding. During the first attack, there is no history of preceding intermenstrual pain. Also, one rarely gets the history of recurring periodic pain. A preoperative diagnosis of a ruptured tubal pregnancy is usually made unless the patient is a virgin, has had the same disorder before, or has had a salpingectomy previously. However, it is difficult to eliminate a ruptured ovarian cyst, abdominal hemorrhage from other sources, and other acute pelvic conditions. Diagnosis of corpus luteal hemorrhage can only be made after a laparotomy is done.

Treatment of this third type of painful ovulation is a laparotomy immediately and suturing of the corpus luteum plus supportive therapy. Shock is combatted with blood and intravenous therapy, complete rest, warmth, and circulatory stimulation. The situation rarely recurs.

HISTORY

Mrs. Daw is a healthy-looking, well-built woman of 42 years of age. She was born in Belgium and came to Canada at the age of 10. Her mother died several years ago of diabetic gangrene—her father is alive and well. She was married in 1942 and her husband is a motorman with an electric railway. She has two children—a girl three years of age and a boy one year. Both births were normal and the children are healthy. She prefers to do her own housework although they are financially able to afford a part-time maid. Mrs. Daw does not seem to worry unduly and always appears happy and content with life.

MEDICAL HISTORY

In the late summer, Mrs. Daw was tired all the time and did not feel in the best of health. She had no pains or excessive bleeding during her periods but had no energy to do the housework or play with the children. Her menses have always been normal with the occasional pain, but nothing out of the ordinary. Her last menstrual period before entrance to hospital occurred between August 1-5 and was normal. On August 1 she had a severe pain in her abdomen—so severe that she had to lie down. This pain lasted about two hours then passed off. A week later, she again had an episode of pain—sharp, lower abdominal pain, with nausea and vomiting. She fainted going to the bathroom. The pain continued until the afternoon when she called her doctor, who did a pelvic examination and gave her some penicillin. The pain lessened for a while but started up again that evening. Then she began to have pains in the shoulder—the left one first, then both. It also hurt her to breathe. The lower abdominal pain did not localize to either side. Mrs. Daw fainted twice that evening and her doctor advised admission to the hospital.

PHYSICAL FINDINGS

Mrs. Daw looked normal on admission. She was not pale and had only minimal abdominal discomfort. There was no flow or vaginal discharge.

On palpation, her abdomen was tender all over, more pronounced in the lower quadrant, but not more on one side

than the other, indicating bilateral trauma of some sort. The laparotomy revealed a cyst in one ovary and a hemorrhage from a corpus luteum in the other. There was some abdominal distention showing irritation of the intestines by some foreign matter—the escaping blood.

LABORATORY FINDINGS

Emergency white and differential, cross and grouping on blood, and urinalysis were done on admission. There were no post-operative laboratory reports.

Urine: pH 6—acid	Normal
All cells—negative	"
S.G.—N.S.Q.	
Protein—0	"
Sugar—+1	
Acetone—+2	Showing dehydration or faulty fat metabolism probably caused by overfatigue.

Blood: W.B.C.—14,200/cu. mm. 5,000—9,000 cu. mm. increased

Polys—72	33—78%
Lymphs—14	18—65% Low
Monos—3	0—9%
Eosins—1	0—6
Staffs—10	0—5 Increased
Blood group—0—Rh +	

Pathological report: Specimen sent from operating room showed part of an ovary in which there is a large corpus luteum showing evidence of hemorrhage.

OPERATING ROOM REPORT

Under spinal anesthesia, the patient was put in lithotomy position and a large needle was passed into the pouch of Douglas. Both free and clotted blood were found, indicating internal abdominal hemorrhage. The patient was then prepared for a pelvic laparotomy. A left paramedian incision was made. On opening the abdomen, a large amount of free and clotted blood was found. Both tubes were normal but the uterus was slightly enlarged. The left ovary showed a cyst the size of a hen's egg, which ruptured on manipulation. The right ovary showed a corpus luteum with a lot of adherent blood clots. This was probably the origin of the abdominal hemorrhage. The corpus luteum was

resected and the base oversewn. The appendix was normal but was removed in the usual manner. The abdomen was closed in layers.

PREOPERATIVE CARE

With an emergency operation such as Mrs. Daw had, there are, of necessity, many preoperative nursing procedures dispensed with, such as an enema. The patient was locally prepared, both abdominally and vaginally, and preoperatively examined by the interne. Mental reassurance is of the utmost importance in cases such as these. A nurse must never show the patient that her case is serious by actions or words. However, since Mrs. Daw is normally an optimistic woman there was little need for reassurance.

She was sent to the operating room with a medication of morphine gr. 1/6 and atropine gr. 1/150 (after voiding). An hour later she returned to the ward in good condition—conscious, B.P. 120/50, P. 124 and bounding.

POST-OPERATIVE NURSING CARE

The patient was placed on her side with one knee drawn up slightly and pillows placed behind her back to make her more comfortable. This position allows a free passage of air at all times, and if the patient vomits or has an increase in salivary secretions she will be less apt to aspirate them and thus cause pneumonia or asphyxia.

Upon return to consciousness, Mrs. Daw was placed in semi-Fowler's position, allowing for better drainage and also causing less strain on abdominal muscles by flexing of legs. As she progressed, she was allowed in high Fowler's position and on the second day was up in a chair. Moving about in bed was stressed from the time of her return to consciousness to prevent any post-operative complications. Deep breathing exercises were also instituted.

Sedation: Morphine gr. 1/3 was ordered q. 3 h. and p.r.n. for relief of pain from operative discomfort. This order only lasts until 48 hours after the operation when such medication is usually not considered necessary. Continued use of morphine is undesirable because of its habit-forming character. A tolerance for

it is rapidly acquired. Mrs. Daw required it only twice. Good nursing care minimizes the need for morphine—i.e., frequent changes of position, use of pillows, etc., to promote the comfort of the patient. Second gr. 1½ was also given at h.s. to promote a good sleep.

Observations: Mrs. Daw's temperature after the operation remained normal and her pulse, respirations, and blood pressure remained constant at all times. There was no excessive drainage from the incision. Good sterile technique was practised, preventing any chance of infection in the wound. On the seventh day, the clips were removed and the incision appeared clean and well healed.

After the first day, there was no vaginal discharge but the area was kept clean by frequent perineal care, preventing any chance of infection through the vagina.

Diet: Mrs. Daw was on a fluid diet for the first 24 hours because she was occasionally nauseated and vomited several times. An intravenous of 2,000 cc. of 5% glucose in saline and a transfusion of 500 cc. of whole blood prevented any dehydration and helped to replenish some of the blood lost as a result of hemorrhage. She improved so rapidly that from the second day until her discharge she was on a full diet, showing that the more rapid the return to a normal diet the more rapid the convalescence. Forcing fluids to 3,000 cc. per day after an operation is very necessary, as it eliminates toxins and prevents dehydration.

Catheterization: If necessary it is done in 8 hours and every 8 hours following until patient voids on her own. Mrs. Daw was catheterized once then voided normally. Catheterization is another method of assuring the comfort of the patient and lessens chances of operative discomfort.

Distention: Post-operative distention can usually be prevented by keeping the patient moving. It can be relieved by insertion of a rectal tube, turpentine stupes, and so on. Distention was Mrs. Daw's only post-operative discomfort. A rectal tube seemed to do much to relieve her.

On the third day, she had a Mayo enema with good results. Being out of bed so soon after her operation and taking walks down the hall helped to make her

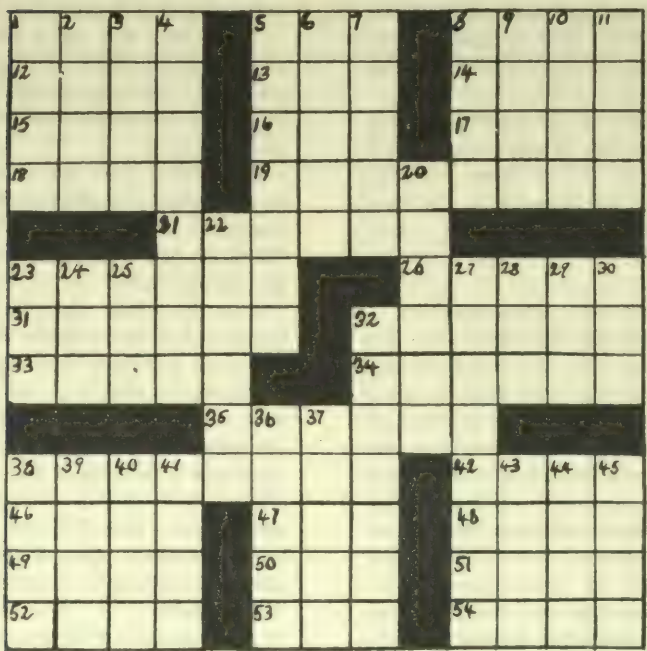
bowels move regularly. No further enemas were necessary.

Post-operative nursing care is extremely important. Without proper care the patient may never get back to her normal self. Alcohol rubs, pillows placed in comfortable positions, and quietness all help to make the patient's stay in hospital more pleasant. Having a cooperative patient is an added incentive.

HEALTH INSTRUCTION

Mrs. Daw was instructed not to do any heavy chores for several weeks to allow her incision to heal well and to prevent any possibility of herniation. She was also instructed to call her doctor immediately if she had the same type of pain again around the ovulation period. Any irregularities in her menses were also to be reported.

CROSSWORD PUZZLE



ACROSS

- 1. Suffer continuous pain.
- 5. A sebaceous cyst.
- 8. Outer covering of beans.
- 12. Plumbum.
- 13. After the manner of (Fr.).
- 14. French word of caution.
- 15. Bone in forearm.
- 16. Angular distance on a meridian (abbr.).
- 17. Jump.
- 18. Doctor who lost his eye.
- 19. Plank frame on flat-bottomed boat to lessen leeway.
- 21. Jumbled vowels plus S.

- 23. Take the orat out of a place for experiments.
- 26. Less common.
- 31. Light up.
- 32. Act of yawning.
- 33. Equilibrium.
- 34. A birth-mark.
- 35. Classify.
- 38. Sun-room.
- 42. Pigmented perforated membrane.
- 46. Goes quickly.
- 47. Greek prefix meaning "through."
- 48. Dreadful.
- 49. Alack and —.
- 50. Long narrow tube (abbr.).

51. A mental impression.
52. Start being obscure.
53. That part of the mind which possesses consciousness.
54. Bird's home.

DOWN

1. Astringent.
2. Suffix indicating a tumor.
3. Terminal part of arm.
4. Of eating; greedy.
5. Divergent strabismus.
6. Comb. form for oil (Greek).
7. Buttocks.
8. Nimbus.
9. The iris, ciliary body, and chorioid together.
10. Prevaricator.
11. Lawyer, surgeon, priest, dentist (abbr.).
20. Treasurer.
22. An extremity and an organ (two words).
23. Edge of wound.
24. Add E to get a purgative drug.
25. Half joyous.
27. Same as diacetin.
28. Abbreviation for a clergyman.
29. This cate will help you learn.
30. This ace is a rose-window.
32. The kind of phobia with a morbid dread of hearing a certain name.
36. Walk obliquely.
37. Making entreaty.
38. Humbug.
39. Fawning.
40. Grassy lands.
41. A shortened helper.
43. Dominate.
44. Angers.
45. Stool.

(Solution on page 920)

The Importance of Breakfast

The nurse who gets up at the last minute and rushes on duty minus breakfast is piling up trouble that will make itself felt sooner or later. There has already been a fasting period of eight hours or more since the last meal on the previous day; another 4-hour period

without breaking the fast is not conducive to a good morning's work. Get up a few minutes earlier for a hot beverage and cereal or toast, at least; better still, make it fruit juice, beverage, bacon and/or egg with toast.

—Dept. of National Health & Welfare

Accidents are far more important as a cause of death among females than is generally realized. Each year a greater number of girls and women are killed by accidental injuries than die from any other cause except the cardiovascular-renal diseases and cancer.

Accidents are the greatest single menace to life in childhood and adolescence. In order of frequency the causes for all ages are falls, motor vehicle accidents, burns, conflagration, drowning.

—M.L.I.C. Statistical Bulletin

Book Reviews

Medical Nursing, by Edgar Hull, M.D. and Cecilia M. Perrodin, R.N., B.Ed., M.S. 826 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 4th Ed. 1949. Illustrated. Price \$4.75.

Reviewed by Clara Aitkenhead, Instructor of Nurses, Alexandra Hospital, Montreal.

This book has achieved one of the chief aims of the authors, in that particular emphasis is placed on fundamental principles. The first unit is very inclusive and comprehensive in general basic facts, a sound knowledge of which is essential to good nursing care. In the remaining units the introductions deal briefly with anatomy,

physiology, and cause of disease, thus the effect of illness should be better understood. The clearly outlined clinical picture of the patient as presented should assist the student nurse in carrying out nursing care and anticipating the special needs demanded by the illness.

Special features include the contemporaneous explanation of new terms; full bibliography with particular reference to current nursing magazines; nursing factors in observation of symptoms; inclusion and explanation of pertinent laboratory tests which, correlated with medical nursing, enable the student to more intelligently understand their value and importance in diagnosis; detailed factors of importance in administering drugs; suggested reviews of basic nursing procedures; and mental preparation of patients, especially for new procedures.

I feel this book is an excellent contribution to the school of nursing library and should stimulate the young student nurse by its detailed yet concisely outlined care of the medical patient.

Essentials of Gynecology, by Leo Brady, M.D., Ethna L. Kurtz, R.N., and Eileen McLaughlin, B.S., R.N. 256 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1949. Illustrated. Price \$3.00.

Reviewed by Verna Williams, Clinical Instructor in Surgical Nursing, St. Boniface Hospital, Man.

This book, in which the authors present the material in a brief and simplified form, will serve as an excellent reference in gynecology.

In the first section the authors present a comprehensive review of the anatomy and physiology of the organs of reproduction. Following this are two very excellent chapters stressing the importance of a complete and accurate history and examination, also one chapter discussing symptoms specific to a gynecological patient.

The diseases and disorders of the reproductive organs are defined and discussed. This material is well organized and clearly presented. There are several chapters relating to gynecological surgery—both operating room and post-operative care. In most instances emphasis is placed on general principles of care rather than specific techniques. One chapter discusses female urology very thoroughly, which topic is not always found in gynecology texts. The last chapter

presents radiation therapy very briefly.

There are excellent illustrations throughout which make it possible to visualize the material presented. A bibliography at the end of each unit would have made the book more valuable by suggesting to nurses additional sources of information.

Graduate nurses who are working in gynecology would find this a valuable reference book and it would supplement lectures given in gynecology to student nurses.

Ward Administration, by Margaret Randall, R.N., M.A. 326 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Price \$4.40.

Reviewed by Carol M. Adams, Associate Director of Nursing Education, Kitchener-Waterloo Hospital, Ont.

Those who are faced with the problem of administering a ward will find Miss Randall's book most helpful and stimulating. Although it was written primarily for students in ward administration courses and for head nurses, it would be valuable to persons in other departments of the hospital who are interested in the welfare of the patient. Miss Randall states in her preface: "The emphasis in this book is placed on democratic administration with the goal of developing each member of the hospital health team so that everyone is stimulated to give patients the best possible care."

It is a comprehensive, well organized, and interesting book, containing a wealth of practical and well-documented information on the various aspects of ward administration. A helpful reference list is included at the end of each chapter.

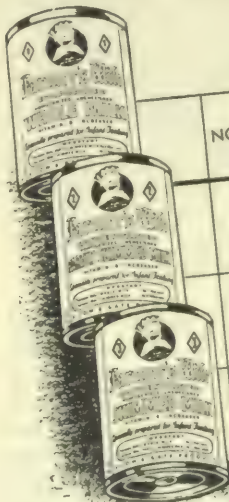
This book is considered a "companion" book to "Clinical Instruction" by Amy Frances Brown. It is divided into six units as follows: Unit I, The Hospital Patient; Unit II, The Environment of the Patient; Unit III, the Personnel of the Patient's Environment; Unit IV, Principles of Administration; Unit V, The Head Nurse's Place in the Hospital Organization and in a Community Health Program; Unit VI, Qualifications and Preparation for the Head Nurse Position.

The author's emphasis is on the administration of a service which is practical, carefully analyzed, and aimed at the individual needs of the patient. Included are discussions on many of the all-important

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NOW!* **3**

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1	RED	8%	4.00%	26.0%	45	Regular Evaporated Milk
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questions of the day, such as team method of assignment, job satisfaction, role of subsidiary workers, methods of assigning patients, and duties and floor coverage.

The author discusses briefly but very frankly some of the disputable questions which head nurses face—for example, case assignment versus functional assignment and problems in medical-nursing relationships.

Methods of conducting studies to evaluate present nursing practice are explained and sample forms included. The scientific approach toward evaluating the nursing needs of patients is emphasized throughout. Some nursing care plans are included for illustration.

Throughout the book the relationships of other departments in sharing the responsibility for administrative service to the patient is clearly shown, together with the essential and invaluable assistance of the head nurse in planning the construction and remodelling of hospital facilities. A short chapter is devoted to the role of the hospital in maintaining community health.

Signs and Symptoms—Their Clinical Interpretation. Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P. 439 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Illustrated. Price \$14.50.

Reviewed by Mrs. Catherine L. Townsend, formerly Instructor of Nurses, Montreal General Hospital.

With names such as Bar, Freyburgh, and Wolff among the contributors there is no question of the excellence of this work which is written for doctors. However, the well prepared clinical teacher in nursing schools may find this a valuable reference. In developing "trained observation" among students this book can be used, first as a guide as to what to look for and, second, as a form of catalogue where one can classify what has been observed.

Twenty-one doctors, specialists in their fields, contributed to this volume. The book is divided into 27 sections each dealing very thoroughly with the subject involved and these subjects vary from pain to pruritis, from joints to jaundice.

This book may be dipped into as a reference but two sections should be read before delving—the first is the Introduction and the second is the chapter on pain.

The Introduction deals with the process of analyzing and interpreting symptoms—the

present illness, the association of symptoms, and the importance of a complete history. This paves the way for intelligent use of the other 26 sections.

The chapter on pain is also a basic one. No matter how distressing other symptoms may be, it is *pain* and the relief of pain that is the prime consideration of the patient.

Each section has a concise summary at the end of the chapter. It is difficult to choose illustrative material from such a wealth of information but there are certain divisions which might serve the nurse well.

The chapter on fever seems particularly good: beginning with heat production and heat elimination it covers the subject from all angles. Then with the stress today on water balance and with "transfusion" and "intravenous" household words, the chapters on dehydration and edema are of great interest. Headache being no respecter of persons I believe Chapter Three to be a very useful one.

When using this text it is necessary to stick very closely to the subject in hand or, as when consulting the encyclopedia, fascinating bits of information will entice you far afield.

Communicable Disease Nursing, by Theresa I. Lynch, R.N., Ed.D. 776 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price \$5.50.

Reviewed by Aileen Flett, Director of Nurse Education, Mountain Sanatorium, Hamilton.

The second edition of this book presents the care of the patient with communicable disease as it may be practised in the modern hospital or in the home.

The content has been carefully reviewed and brought up to date emphasizing the modern concept of treatment, methods of control, nursing care, patient education, and rehabilitation. The book is divided into five parts: Orientation to communicable disease nursing; medical aspects and nursing care of communicable diseases; tuberculosis; venereal disease; communicable diseases and the community; while the less common communicable diseases are dealt with in an appendix. The pictures and graphs illustrate the subject matter well.

The salient points in each chapter are summarized under Essential Points to Remember and Community Protection with references and suggested readings.

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In Orientation, page 36, this statement occurs: "B.C.G. vaccination is advised in some institutions for nurses who react positively to the tuberculin test." This is an obvious typographical error as B.C.G. is of value for nurses who are negative reactors to tuberculin.

The text is comprehensive and of more than usual interest. It should prove useful as a guide to instructors, a reference book for nurses, and a text for students.

A Handbook for Industrial Nurses, by Marion M. West, S.R.N., S.C.M., with contributions by Valerie Bowerman, S.R.N., and H. F. Chard, M.B. 264 pages. Published by Edward Arnold & Co., London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1949. Price 75 cts.

Reviewed by Theresa Greville, Industrial Nurse, Winnipeg, Man.

The author has given a history of one hundred years' growth of welfare work, labor legislation, and industrial nursing in England—from 1842 to the post-war legislation of 1948 under the present Labor Government.

The duties and responsibilities of the industrial nurse are outlined with a wealth of detail. Nothing is forgotten—from the furnishing of the first aid department, specific treatments for occupational and non-occupational illnesses and accidents, to the hours of duty and suggested salary; how to present reports, with samples of form letters; a special chapter on eye injuries written by Dr. Chard—to the dangers of the nurse working alone and assuming responsibilities beyond her sphere. Professional ethics is defined as "the practical application of the Nightingale Pledge."

The book could well be used as a manual for a study group. Attention should be given to the fact that some expressions in the book are not in use in industrial literature on this continent. Nurses guided by the contents of the book could study their own federal and provincial legislation for the protection of workers.

There is no gaiety or humor in the book. It bristles with starched efficiency but, nevertheless, it is not only a book industrial nurses should read but they should keep it at hand for constant reference. There is an index that the busy nurse working alone will appreciate.

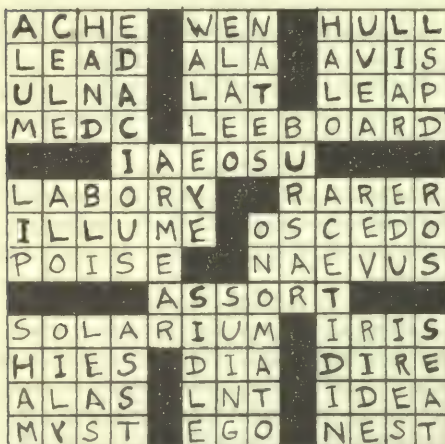
Leading Causes of Death

Diseases of the heart are now responsible for one-third of all the deaths in the United States, three times the proportion in 1910.

The accompanying figures show the change that has taken place during the past 37 years.
—*M.L.I.C. Statistical Bulletin, June 1950*

**Rank of Five Leading Causes of Death in Specified Age Groups,
White Persons, by Sex. United States, 1947 and 1910**

MALES				FEMALES			
1947		1910		1947		1910	
<i>Cause of Death</i>	% of all Causes	<i>Cause of Death</i>	% of all Causes	<i>Cause of Death</i>	% of all Causes	<i>Cause of Death</i>	% of all Causes
All Ages							
Diseases of heart	35	Tuberculosis	11	Diseases of heart	31	Diseases of heart	11
Malignant neoplasms	13	Pneumonia and influenza	11	Malignant neoplasms	17	Pneumonia and influenza	11
Accidents	8	Diseases of heart	10	Cerebral hemorrhage	9	Tuberculosis	10
Cerebral hemorrhage	7	Accidents	8	Nephritis	6	Diarrhea and enteritis	8
Nephritis	5	Diarrhea and enteritis	8	Accidents	5	Malignant neoplasms	7



Story of Marmalade

In the 18th century a Scottish grocer, James Keiller of Dundee, heard that a storm-bound Spanish ship had taken refuge in the port. Its cargo of sugar and oranges was going cheap.

Never one to miss a bargain, James went out to buy. He took the oranges and sugar home to his wife, who had a family reputation for her quince jelly.

She concocted a new preserve which she tried on her family and friends. They liked it. James then tried the marmalade on his

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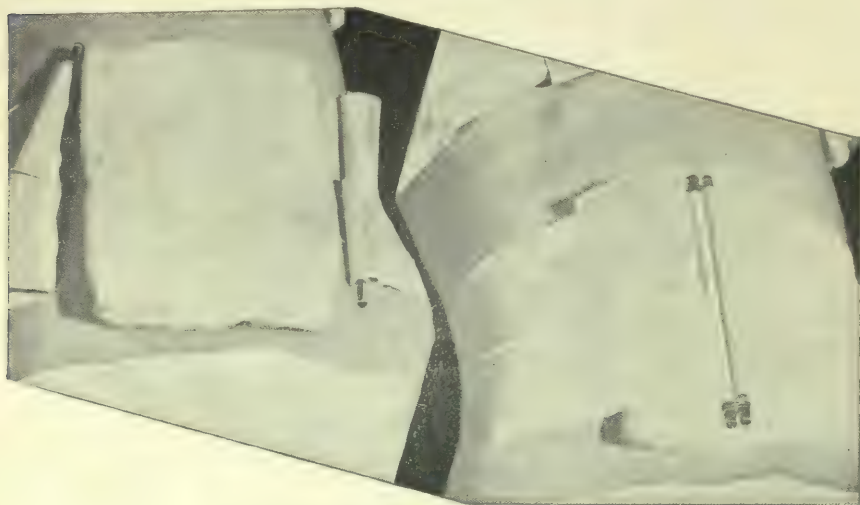
IN THE TREATMENT of gaping abdominal wounds or after laparotomy, where frequent change of dressing is required, the following appliance may be used.

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position and to render a portion of the dressing non-adhesive.

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VOLUME 46
NUMBER 12
MONTREAL
DECEMBER
1950



THE CANADIAN NURSE

Merry
Christmas
and
Happy
New Year



Welcome to the



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... and the
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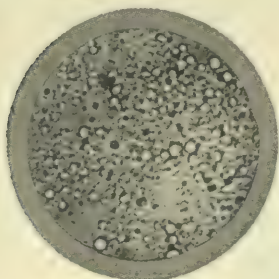
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The Canadian Nurse

VOLUME 46

NUMBER 12

DECEMBER, 1950

NEW PRODUCTS.....	942
UNTO YOU IS BORN.....	947
CHANGING MATERNITY SERVICE IN A CHANGING WORLD.....	<i>H. Corbin</i> 949
NURSES' PART IN A PRENATAL PROGRAM.....	<i>K. McIlraith</i> 957
PRENATAL CLASSES IN GREATER TORONTO.....	<i>C. Gray</i> 960
NOURISHMENT FOR A PREGNANT WOMAN.....	<i>L. Randoïn</i> 963
TOWARDS EASIER CHILDBIRTH.....	<i>J. Barnes, M.D.</i> 964
NURSES' PART IN POSTNATAL CARE.....	<i>H. Lusted</i> 966
BREAST FEEDING.....	<i>H. B. Bourne, M.D., C.M.</i> 969
A MOTHER BREAST FEEDS HER BABY.....	<i>M. D. Anderson</i> 972
"HAMLET" ON THE MATERNITY WARD.....	974
LYLE CREELMAN WRITES.....	976
NURSING PROFILES.....	978
CARE OF "HIS MAJESTY".....	<i>L. P. Bell</i> 981
PUERPERAL INVERSION OF THE UTERUS.....	<i>W. S. Holmes, M.D.</i> 983
APERÇU SUR LE SERVICE SOCIAL À L'ASSISTANCE MATERNELLE.....	<i>F. Verret</i> 985
WRAPPING YOUR CHRISTMAS PARCELS.....	988
TRENDS IN NURSING.....	989
ORIENTATION ET TENDANCES EN NURSING.....	991
HEMOLYTIC DISEASE.....	<i>R. Kelley</i> 995
BOOK REVIEWS.....	996
NEWS NOTES.....	1003
OFFICIAL DIRECTORY.....	1016

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE nor of the Canadian Nurses' Association.

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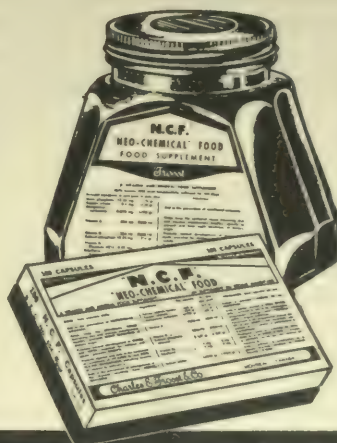
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Between Ourselves

One glance at the *Table of Contents* in this issue will demonstrate the wide coverage that has been given to various aspects of **obstetrics and pediatrics**. Even with such diversified topics as we have included, we have scarcely touched the fringe of the whole wide range of the maternity cycle. It would have required an enormous volume to provide anything like a complete picture.

Prenatal supervision of the expectant mother is a twentieth century development. The shocking incidence of maternal deaths, due in large part to preventable causes, startled health authorities, the medical profession, and the country out of their complacency during and after the first World War. Since that time revolutionary changes in obstetrical practices have taken place.

Much of the pioneer work in this direction was initiated and spurred by the remarkable record established by the Maternity Centre Association in New York City. Established in 1918, the Centre has demonstrated the results that can be obtained when good maternity care is provided. In the light of the phenomenal record of service this organization has afforded to women, its value as a teaching centre to many nurses from Canada, and the stimulus it has given to the provision of more adequate supervision of the maternity cycle, we are delighted to begin our series of articles in this issue with **Hazel Corbin's** challenging "Changing Maternity Service in a Changing World." Read that article without fail! This paper, presented at the Nurse Midwifery Section program meeting (May 11, 1950) at the biennial convention of the National Organization for Public Health Nursing in San Francisco, was published in the August, 1950, issue of *Public Health Nursing*. It is reproduced here through the courtesy of that publication and Miss Corbin.

* * *

Apropos our general topic this month, we were very interested to receive word of a new publication that has recently been made available through the Committee on Prenatal Education of the Welfare Council of Greater Toronto. Entitled **A Guide for Teachers of Prenatal Classes**, the contents include an outline of the material given in 10-class series sponsored by the committee.

The Guide also includes a list of references and a bibliography, samples of some of the forms used, and an outline of the duties of the volunteer and the librarian. This material will be of considerable use to any nurses who are conducting prenatal classes or who are interested in organizing such classes in their own community. For the price of **\$1.00**, copies may be obtained from the *Secretary, Health Division, Welfare Council of Greater Toronto, 100 Adelaide St. W., Toronto 1, Ont.*

Constance Gray, who is one of the members of this committee, writes from her own experience with this form of instruction in the article in this issue.

* * *

The happy family group on our cover shows Mr. and Mrs. Wm. D. Crowwhite, Jr., and their three children. The six-day-old new daughter was born last summer.

* * *

We cannot close the year and **Volume 46** without some expression of our appreciation for the loyal and generous support given to the *Journal* by so many of you through the months. To the nurses of New Brunswick who are lined up solidly behind us as 100 per cent subscribers; to the *Canadian Nurse* Committees and their conveners, both provincial and in the local organizations who have aided in securing articles, in sending in items of news, in rounding up subscriptions; to the dozens of contributors whose articles you have read with interest and with profit; to the busy nurses who have willingly crowded in the extra bit necessary to make our Book Review section a success; to all of you who have written us letters of commendation and encouragement—our sincere thanks. Perhaps one of the most heartening changes in point of view, that we cannot help but comment upon, is in the pronouns you use when speaking of or writing regarding the *Journal*. Almost always you say "our" *Journal*, not "your" *Journal*. For our *Journal* it most assuredly is! We look forward to increased cooperation and support in the New Year that will soon be here.

* * *

A Very Happy Christmas to each of you and a Prosperous New Year!



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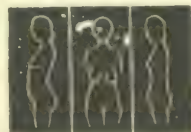
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Manufacturer—Sharp & Dohme (Canada) Ltd., Toronto.

Description—Each pleasant-tasting Tracinets Troche contains: Bacitracin, 50 units; tyrothricin, 1 mg.; benzocaine, 5 mg.

Indications—Prevention and treatment of gram-positive throat and mouth infections accompanied by no elevation of temperature. Also following tonsillectomy or surgical procedures of mouth and throat. Valuable in Vincent's infection, streptococcic pharyngitis and tonsillitis (combined with parenteral penicillin therapy).

Administration—One dissolved slowly in the mouth, every three hours for 4 or 5 days.

GERICOLE

Manufacturer—Sherman Laboratories, Windsor, Ont.

Description—Each teaspoonful (5 cc.) contains: Choline dihydrogen citrate, 250.00 mg.; inositol, 100.00 mg.; ascorbic acid, 75.00 mg.; thiamine hydrochloride, 12.50 mg.; riboflavin, 1.25 mg.; pyridoxine hydrochloride, 0.25 mg.; niacinamide, 12.50 mg.; calcium pantothenate, 2.50 mg. In a palatable syrup flavored with orange.

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Manufacturer—Sherman Laboratories, Windsor, Ont.

Description—An aqueous solution containing 25,000 units of estrogenic substance and 25 mg. of progesterone /cc.

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Administration—Usually 1 cc. intramuscularly 1 injection is sufficient but in some cases it may be necessary to repeat the treatment after 25 days.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Elizabeth (Sharp) Cawley* (Hamilton Gen. Hosp. and University of Toronto general course) and *Barbara Gilroy* (Toronto Gen. Hosp. and U. of T. gen. course) to North York board of health; *Muriel Currie* (Royal Victoria Hosp., Montreal, and U. of T. gen. course) to Sault Ste. Marie board of education; *Mary (Kerswill) Westcott* (T.G.H. and U. of T. gen. course) to Etobi-

coke Township board of health.

Resignations: *Dorothy (Ball) Donnelly* as public health nursing supervisor, Simcoe County health unit—also from same unit: *Verna Smyth* to pursue post-graduate study, *Eileen Kirton* and *Margaret Marshall*; *Gertrude Dickey*, *Loreen (Tyson) Harvey*, and *Beulah Holt* from Elgin-St. Thomas health unit; *Margaret Powell* from Ottawa public school service; *Florence Stewart* from Peel County health unit.

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The

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Unto You is Born

And there were in the same country shepherds abiding in the field, keeping watch over their flock by night.

And, lo, the angel of the Lord came upon them, and the glory of the Lord shone round about them: and they were sore afraid.

And the angel said unto them, Fear not: for, behold, I bring you good tidings of great joy, which shall be to all people.

For unto you is born this day in the city of David a Saviour, which is Christ the Lord.

And this shall be a sign unto you; Ye shall find the babe wrapped in swaddling clothes, lying in a manger.

And suddenly there was with the angel a multitude of the heavenly host praising God, and saying, Glory to God in the highest, and on earth peace, good will toward men.

LUKE 2: Verses 8-14

IT SEEMS particularly appropriate that an issue of our *Journal* that is devoted almost exclusively to the care of the expectant mother and her infant should be associated with the Christmas season, when we celebrate the birth of the Christ-child.

Modern obstetrical practices in Canada are very different from those primitive surroundings of nearly two thousand years ago. Then, there was no such thing as prenatal care by qualified physicians and nurses. There were no maternity hospitals, emblems of shining efficiency. There was not even a bed available in an inn for the young woman who was shortly to give birth to her first Infant.

Probably she was as terrified as any young mother would be today at the prospect of having her Babe away from the shelter of her own humble home, surrounded by crowds of strangers. Pushed about, weary, in pain, the stable must have seemed a veritable haven on that night so long ago.

Even the excitement created by the radio transmission of news of important events in the world today is eclipsed by the magnificence of the chorus of the "heavenly host" that heralded the newborn Babe. "Good tidings of great joy, which shall be to all people," the angel said. We, in the middle of the twentieth cen-

tury, tend to be a bit blasé about so many things. Yet the angel's message was addressed, not just to a particular group of persons, not to any one race or creed but to "all people." Thus if we today accept the story of Christ's birth, in any degree, we should accept the whole inference of what His coming meant on earth. For the angels prophesied "on earth peace, good will toward men."

As the coming of a new infant brings happiness to the hearts of his parents, so may this anniversary of the Babe born 1950 years ago bring to all of us

peace and good will. We need them both so badly in our everyday affairs, in our personal lives. Science has brought us improved practices in obstetrical care, new techniques for the safeguarding of the health and well-being of mothers and babies, better knowledge and understanding of the importance of mental health for the whole family, but it has not given us any prescription for finding "on earth peace, good will toward men." The good tidings of the angels are still the surest way to find both. May the spirit of Christmas live on in each of us!

Some Vital Statistics

The preliminary report for 1948 of the Vital Statistics Section, Health and Welfare Division, Dominion Bureau of Statistics, has recently been issued.

Masses of tabulated figures sometimes appear boring but when it is realized that these represent the annual end results of the active programs for the health conservation of millions of Canadians, the figures take on new meaning. For instance, 347,307 new citizens were registered as live births—a rate of 27.0 per 1,000 of the population. This was a drop of 1.6 per 1,000 from the previous year but is still higher than the average rate over the past 25 years. There were two sets of quadruplets, 36 sets of triplets, and 3,940 pairs of twins born during the year.

Stillbirths showed a continuing decline—19.7 per 1,000 live births as compared with 31.5 per 1,000, 25 years ago. A total of 6,849 pregnancies that terminated in stillbirths meant a great many heart-aches to parents.

The neonatal mortality figure (deaths of infants under 1 month), 8,897, produced the same rate as the year before—26 per 1,000 live births. These deaths accounted for more than half of the total deaths of infants under one year of age—15,164.

British Columbia had the lowest infant mortality rate of any of the provinces and in its provincial history—33 per 1,000 live births. New Brunswick was highest with 61. Quebec had a new low of 54.

Prematurity still led as the greatest cause of infant deaths, with congenital mal-

formations second. Diarrhea and enteritis continued to take far too heavy a toll, accounting for 1,472 deaths. Birth injuries and bronchopneumonia each caused 1,451 deaths. These five causes were responsible for 10,259 of the deaths of infants under one year—just over two-thirds of them. These figures clearly indicate where more stress needs to be placed in the infant welfare programs in our country. What can be done to reduce the number of premature deliveries? Can the number of birth injuries be lowered by increased care at the time of the delivery?

A total of 510 women died from maternal causes, producing a rate of 1.5 per 1,000 live births. With all of our new knowledge of blood chemistry and with the remarkable range of antibiotics that are available, this rate should continue to fall. Increased prenatal supervision to discover potential difficulties is a real challenge.

The biblical life span of "three score years and ten" has long since been outstripped. During 1948, 48,178 of the deaths that occurred or 40.3 per cent were of persons over 70. In fact, there were 672 who had lived to be over 95 before they passed away.

The ten leading causes of death for all ages and their rate per 100,000 population during 1948 were: diseases of the heart, 263.6; cancer, all forms, 126.4; cerebral hemorrhage, 79.1; violence, including car, train, and air accidents, 69.7; nephritis, 52.9; pneumonia, 44.3; pulmonary tuberculosis, 31.2; diabetes, 20.3; diseases of the arteries, 18.3; diarrhea and enteritis, 14.0.

Changing Maternity Service in a Changing World

HAZEL CORBIN

Average reading time — 26 min. 12 sec.

TOO MANY PEOPLE have looked into the blank faces of children in displaced persons' camps ever to be satisfied again with the *status quo*. The product of broken homes, deprived of their birthright of love, even in some cases of their identity, these children are the epitome of a lack of security which is the chief disturber of the peace—international, national, and personal—in this day.

The young men who have been to war, deprived of their normal family life, the young women who have pulled up their roots and trundled from town to town and city to city after their soldier husbands until they said "goodbye" at some port of embarkation, know what lack of security means. These young people now place a high value upon the homes they are setting up and the physical and emotional security they are trying to build for themselves. They are resolved to achieve and maintain this security. Those who have an interest in a better tomorrow see in this family security one of the keys to national and international strength and security. It is the people who have built for themselves a firm foundation who may yet wield the balance of power in a world torn by opposing forces of almost equal power. Wherever you look today, you see inconclusiveness of political or social action because the pros and cons are almost equally matched. Mr. Attlee finds it difficult to carry on a government policy when his opposition is almost as strong as his support. Belgium is almost equally torn between those who are pro- or anti-Leopold. In our own land (U.S.A.), the last popular vote for President indicated that

Republicans and Democrats are nearly equal in number. Most constructive and progressive legislation is stymied in Congress because opposing forces are nearly equal. This neat balance at which the world has arrived causes instability and lack of forthright action in any direction. This neat balance, however, can be shaken by only a few. A few shots fired by hotheads could cause a world cataclysm; a few words of wisdom by people who are secure in the midst of insecurity could help to break the deadlock. We who are working at the very roots of family security have upon our shoulders a momentous responsibility in these times.

The value which our young people are placing upon security in the family is evidenced by the rise in the birth-rate contrary to the prophecies of the statisticians. The year 1949—the year when all the experts believed the big postwar drop in the number of births would occur—produced the second largest baby crop in the history of the United States.

Worldwide forces have intruded even into the techniques and methods of obstetric and pediatric care. The trends which we see today in these two fields are without doubt the result of a search for security in an unstable world; for it is the young married people who have been through the disorientating experience of war—eager for security, resistant to unreasonable regimentation—who are the consumers of maternity and pediatric care. They are looking for security when they have their babies and they highly prize being together to share the great experience. Child-birth is, as one young mother wrote, ". . . the most intense experience I expect I will ever have this side of death. It certainly is the supreme

Miss Corbin is general director, Maternity Centre Association, New York.

time in one's existence." Young people want to make the most of this supreme time. They do not want to be cheated emotionally or physically and they have a right to make this demand.

THE PATIENT AS A CONSUMER

Notice, I use the word *consumers* of maternity and pediatric care. That expresses a changed concept which is having and will continue to have an increasingly profound effect upon the provision of care. Not many years ago a large proportion of the people who had their babies in hospitals went there because they had no other choice. They entered the charity door and they lay upon charity beds. The charity, however, which was dispensed was only faintly redolent of that described by St. Paul as "the greatest of these." The patients took what was provided whether they liked it or not because there was nothing they could do about it. I remember entering a maternity clinic before the war where the air was fetid with the odor of bodies like the New York subway at rush hour. On the hard benches sat a grim lot of women waiting for their numbers to be called. Others stood around unable to find seats. I asked the famous professor who headed this obstetric service, "Why not provide at least enough benches for these mothers to sit on?" He replied offhandedly, "Oh, they don't mind standing—they're used to it!"

Today everybody pays in a hospital. The ward beds cost as much in many institutions as private rooms five years ago. In addition, an increasing number of the people who used to be charity patients or teaching material have paid their own hard-earned money for insurance policies of the Blue Cross or Blue Shield or other company or union-organized medical or hospital plans which state that they are entitled to care without the stigma of grudging charity. They do not want to be a number or to be patronizingly called by their first names. They don't want to be told to sit there or come here. They don't

want to be examined needlessly by numerous medical students while the private patients are treated with respect. They do not want to have their visitors limited or barred because of "the danger of infection" while they see a stream of visitors to the private pavilion where, for some reason, the danger of infection does not limit visitors. They want simple, warm-hearted acceptance. They want the same thing you would want for yourselves or the doctor for himself if you or the doctor were the patient. In addition, they pay for their insurance and they expect their money's worth. Therefore they reserve the right to speak out when they don't like the care they receive. They reserve the right to select their doctor or hospital as they would the other services or commodities bought in the open market—whether it be an armchair or fresh fish.

THE CONSUMER IS REBELLING

Is it not understandable then that a clash should arise between these consumers with their newly found economic power, their searching demand for security, their distaste for unreasoning discipline, and the suppliers of that care—the doctors, nurses, hospital administrators? The root of that clash is found in an attitude of mind among the people who provide the care—from the hospital board member to the receptionist in the clinic. Many of these people don't recognize that a revolution has already taken place in the minds of the consumers. They still speak of the "indigent" or the "medically indigent" as if they were different kinds of people from those who were able to pay their way in full. They still divide the sheep from the goats, with one kind of treatment provided for the sheep or the private patients and another for the goats or the ward and clinic patients. Medical charity has put its chief emphasis upon making it as simple as possible for the doctor and the nurse to care for the largest number of patients at the cheapest cost without full regard for the effect of this upon the personality of the patient. It has applied

the mechanized economics of the mass production assembly line to human beings. This kind of care ignores the findings of psychosomatic medicine and the relation of the emotions to physical health, and of all this to sound, happy family living.

In addition, medical care is dispensed under a discipline which is autocratic, against which today's young parents are in revolt. The doctor says, "Take this prescription." It is an order. If he is asked why, he may simply say, "Because it is good for you." He may oppose having expectant parents taught anything at all about reproduction because it causes them to ask questions which take time to answer, and he is busy. He may talk about a mother in long medical terms to a colleague while she lies before him on an examination table all aquiver, understanding nothing he says. The doctor may tell Mrs. Jones not to bother her little head about her labor. "When you come to the hospital, we will give you a whiff of something to knock you out, and we will take care of everything," he says in a dignified and rather superior manner. This may be entirely regardless of the mother's own desire to take part in the birth of her baby and to be present when he is born.

These young people who put such a premium upon being together, upon family security, are separated from the moment the husband brings his wife to the hospital door to have their baby. He is firmly but gently ejected from his wife's room or bedside and too often even from the hospital. The baby is separated from its mother as soon as it is born and from its parents during the stay in the hospital. Often the mother is not even consulted about whether she will nurse her baby or not. She is simply given a standard dosage of stilbestrol to dry up her milk supply. She lies in bed with empty arms while her baby may be seeking cold comfort from an empty bottle propped on a diaper.

The clock has become the symbol of this regimentation. The system of hospital care with scheduled hours for

nurses, shifts of duty, meals and visiting hours, admissions and discharges requires scheduled times for feeding the baby regardless of the rhythm of the baby's own demand for food.

TEACHING PROBLEMS

As for teaching, that is shrugged off in many hospitals with a perfunctory session of instruction on diapering or bathing the baby. Often nothing is taught the parents about how their baby is conceived, how he grows and is born, of the adaptations the mother's body makes to supply her needs and the baby's, and the effect of all this upon her emotionally; nothing about the reasons for various techniques of medical care; nothing about nutrition and its importance to the healthful growth of the baby and the health of the mother; nothing about what to expect during labor; nothing about what a newborn baby is like and what he needs; nothing about family relationships at baby-coming time. Many of these hospitals affiliated with universities are called teaching institutions, but whom do they teach? Certainly not the parents. The emphasis is on teaching the medical and nursing students. And yet what is the function of medical care in this land where public health is so much talked of?

A grievous sin is committed against humanity when obstetric teaching takes priority over obstetric care. In no other specialty of medical care is the medical student permitted to assume responsibility for the life of the patient—in this instance two patients: the mother and her baby. Few medical students are permitted to do even minor surgery but every medical student has a number of opportunities to deliver women, often supervised only by an interne, himself still a student with much to learn. It is in this atmosphere of the blind leading the blind that the nurse is taught. At the centre of this teaching experience is the forgotten woman—the mother.

It is upon her and her baby that all interest should be focused. When

maternity care of the best quality is provided the teaching opportunities are manifold but, in order to teach, a qualified teacher must be present to teach the students. And if nurses and doctors are to learn how women have babies and how they can be helped throughout labor, then one or the other must sit with the woman.

A growing number of doctors are disturbed by this lack of good teaching of medical and nursing students in situations where the mother is not the focus of interest—they see its influence on both the students and the mothers. They have observed the damage done to a woman who is treated as a uterus, to the family treated as pegs in a board to be moved at will.

OBSTETRIC PRACTICES

More than that, many doctors are keenly conscious of the number of needless deaths among newborn babies due to anoxia caused by anesthesia—babies with apparently perfect bodies whose heart-beats ceased before they could be made to breathe. These doctors warn that many neonatal deaths are due to brain damage in the respiratory centre caused by lack of oxygen. Dr. Alfred C. Beck, professor emeritus of obstetrics at the Long Island Medical College, puts it this way:

When the mother's respirations are slowed and made more shallow by the use of sedative drugs and anesthetics, the oxygen supply to the placental lake is diminished, and the danger of intra-uterine anoxia and asphyxia are increased to such an extent that most of the methods which have been recommended for the relief of pain during labor may cause the death of the child if they are not given with caution.

Beck is not alone. Many others from various fields are saying the same thing—Snyder of Harvard, Stone of Yale, Darke of Pennsylvania, and others.

In addition, the epidemics of infantile diarrhea which suddenly sweep into a hospital nursery, terrorizing not only the parents but the professional personnel as well, cause many a doctor

to question the present system of caring for babies in large nurseries. Others who have witnessed the unsatisfactory after-effects of routine episiotomies among hundreds of mothers are beginning to question the practice of substituting a routine surgical operation for what might be a routine spontaneous delivery.

To add to the dissatisfaction within the pale of maternal care, many nurses are not attracted to obstetrics. They have no desire to participate in care which separates mothers from their babies and their families by rules and gloves and masks and routines. They see the importance of love and affection and security at this important time in the life of each family and yet they are unable to afford the mothers under their care the opportunity to cuddle or love their babies or to develop a feeling of security. Some see the coming of a baby as an ideal time to teach the facts about reproduction and healthful, happy family living which are omitted from almost everybody's education. But there is no time, no place in the day's work for such teaching.

Often we hear such comments from nurses as, "We are not allowed to stay with women in labor. It interferes with the medical student." Or "Where we do attend women in labor, we must go off duty at a specified hour, even though the mother begs us to stay with her, and we want more than anything else to remain until the baby comes."

Thus the system stands between the patient and her professional helper. The nurse who has ideas and ideals resents the system and is unhappy under it. She hears about the medical team of doctor, nurse, technician, and patient but, as she goes about her daily job, she feels the team is not in harness. Little opportunity for professional creativeness is provided in this branch of medicine concerned with nature's supreme creation.

Leaders in medical care are greatly perturbed as they see the nutritionist intent on food values, not people, the laboratory workers on bacteria, the housekeeper on her laundry, the

medical board intent on medical matters and research, and the administrator on economy and efficiency. The board of directors of the hospital in whose hands the community vests the power frequently doesn't know what goes on within the hospital in terms of people but considers the job well done if the halls are clean, the windows washed, and the building filled with bustling activity.

NEW DEMANDS

The laws of supply and demand are beginning to operate in medical care as they do in the sale of automobiles or refrigerators. We can no longer sit on an Olympian peak and determine what shall be done to people without considering what people want. In the last analysis they must pay for it, directly out of pocket or indirectly through taxation. When people want something, it is produced. We see a demand developing from the public and the professions alike, a demand for a different kind of obstetric care centred on the needs and desires of the mother and her baby as part of a family group.

In response to these desires and demands, little by little and step by step the shape of things to come is beginning to take form in the research centres of a number of great universities, in the wards and private rooms, in the clinics and nurseries of certain important hospitals, in the private offices of sensitive obstetricians and pediatricians, in their daily rounds among their patients, and in their work in the maternal and child health centres; and in the everyday relations of nurses with parents and doctors.

In response to young parents' demand for more knowledge and their resistance to the autocratic "do what you're told" system, classes on a high level of instruction are being organized for both mother and father and conducted under various auspices. Parents with a keen desire to know about childbearing scorn the traditional mothers' or fathers' classes with their chief emphasis on baby care and pink and blue ribbons. These eager young

people want to glean every last scrap of information they can—for a purpose: they want to know how to live during pregnancy and how to prepare for labor so they can participate actively in the job. And the mother wants to do it with her eyes open and to see what goes on. She wants to be the first to announce, "It's a boy."

Armed with such information, young parents are able to understand the reasons for medical or nursing techniques. They know why the doctor does this or that at certain stages of pregnancy or labor. But more, they learn how knowledge can build within them a feeling of supreme confidence in their ability to have their babies according to nature's plan in which they do the work and reap the reward.

Caring for mothers as well educated as this is a challenge to the doctor and nurse. Their functions in obstetrics are changed. No longer do they hold a mystical power, no longer do they do something *to* the patient. Rather they become the coach and sympathetic guide as well as teacher and competent practitioner during labor. For many doctors and nurses this adjustment is difficult in the extreme. For others, still only a few, it has become a challenge to their knowledge and ability to work *with* people rather than *for* them. This is a testing time for the quality of the contact established between doctor, nurse, and mother, and all get tremendous gratification out of this intimate teamwork. As both parents take a more active role, doctors and nurses modify their techniques and methods. For instance, as the exercises for relaxation become important in obstetrics, the doctor and nurse learn how to provide the necessary support during labor within the facilities provided by the hospital.

Even the technique of relaxation has altered some of the early signs of labor, for a relaxed woman is often far along in labor before she, her husband, the doctor, or the nurse recognizes it. Many a primipara has brought forth her baby in from one to three hours after admission to the hospital because her early labor was

not uncomfortable enough to her or significant enough to her doctor to warrant an earlier trip to the hospital. This means that we must revise our teaching about the early signs of labor; it also means we must make some first-hand observation of what happens during late pregnancy and early labor, and we will be wise if we listen well to what the patient and her husband have to say about it.

SHARING THE BIRTH EXPERIENCE

Perhaps one of the most important of these changes is the recognition that the laboring mother needs human companionship. One of the greatest mistakes ever made in obstetrics is the custom of leaving the woman in labor alone and uninformed. It is then that fear grips her heart and anxiety beclouds her mind. It is then that pain overwhelms her and the demand for complete anesthesia becomes insistent.

The hospitals which have permitted the husband to stay with his wife during labor, and in some cases to be with her in the delivery room, are finding that these procedures, unorthodox as they may seem, increase the emotional security of both husband and wife during this important event in their lives. When a woman wants and has her husband with her during this important time to coach her and to love her and to help her relax, the demand for complete oblivion diminishes. Less anesthesia means fewer babies dead or injured from anoxia. It means more mothers conscious and keenly aware of what happens in the delivery room. But it also means a revolution in the technique of delivery and in the administration of the obstetric department. Doctors, nurses, and administrators are learning to adjust to the husband's active part in helping his wife to relax in the labor room and the delivery room. Often this causes extreme difficulty because hospitals were not built or organized to accommodate the husbands during their wives' labor and delivery.

The security which develops among the parents and the revolution re-

quired in obstetric management are graphically portrayed in this scrap from a mother's description of her first baby's birth:

It took only a few good shoves till I felt my baby's head pop out and her body coming out. It felt like a swimming goldfish. Bob was standing at the peep hole so we yelled back and forth through the glass and grinned at each other.

Yes, if these demands of parents are to be met, it is going to take a bit of imagination, more knowledge, an improved relationship between doctors and nurses, and a wagon-load of courage. Yet the doctors who have those qualities today are finding that for them normal obstetrics becomes more interesting and more satisfying. As one physician wrote:

It's more emotionally satisfying to the doctor to care for a conscious mother who talks with him as he directs her efforts in labor than to sit with one who is trying to crawl up the wall, muttering incoherently from analgesia.

Obstetric nursing, too, becomes a thrilling and interesting experience as the nurse learns to help the mother relax and work so she can have her baby naturally. It is a challenge to her teaching ability and to her knowledge of anatomy, physiology, obstetrics, and people.

The hospitals which have worked out methods of keeping mother and baby together, call it rooming-in or what-have-you, have watched the blossoming of security in the faces of both parents. Not only is the family unit knit closely at the very earliest possible moment, but the mother and father who learn to care for the baby under supervision in the hospital develop a feeling of confidence. The young parents who take the baby home after such an experience are ready and able to assume their full responsibility. They are not taking home a baby wrapped in cotton and cellophane they are afraid to touch.

THE CROSSROADS

Are we ready to apply this new relationship between professional staff and parents, and the new techniques of maternity care which are springing

up in response to popular demand and professional dissatisfaction, to obstetrics in big city clinics and country doctors' offices, in hospital delivery room, and farm-house bedroom? "Stop, look, and listen!" . . . "Proceed with caution." . . . "We need more research before we dare make universal such changes in obstetric care," warn some of the less imaginative and adventurous.

True it is that medical progress is dependent upon research. The more we know, the better can be the care provided. But is it lack of research, lack of knowledge that stands in the way of obstetric progress? Or are we in the doldrums? Are we the victims of tradition—tied, like Marley, to a rusty system? Are we tarred with the same brush as a recent contributor to *The Lancet*? said a British doctor:

A public avid for medical knowledge is a public to be pitied . . . The profession was able to do much more good when the public had unquestioned confidence . . .

The less they know, the happier they are.

Have we oversold ourselves on institutional, mechanized care? In order to make more efficient the care provided in hospitals, have we lost the essence, the heart and soul of that care? I think we have! With proper safeguards properly centred in our community a home service offers something very wonderful that is all too often lost entirely in a hospital. The problem is not so much one of lack of knowledge as of attitude. Are we going to stand idly by and let anesthesia take the place of education; chemotherapy supplant known methods of preventing infection; blood transfusions replace a loss of blood which might have been prevented? Are we going to accept routine episiotomies and delivery by forceps rather than assistance to the mother in delivering naturally by using the muscles designed for this purpose?

We nurses stand at an important crossroads. Shall we continue to be merely the hands and feet of others when often we disagree? Or shall we take our place with the leaders of the medical profession and the community at large?

RULE OR REASON

The direction which nursing takes in the future is at this very moment being decided in countless little episodes such as this:

Recently a well trained nurse who had specialized in obstetrics for years attended her sister in a university hospital. Her sister had had her first baby normally with a very short labor. In this second labor, things progressed as expected. When fully dilated, the mother was taken to the delivery room—but her doctor had not yet arrived. Two or three more contractions and the baby would be born. However, against the patient's protest, her legs were held together to hold the head back and she was ordered anesthetized.

The well trained obstetric nurse urged that the baby be allowed to deliver rather than held back but the supervising nurse said, "No, we must wait until the doctor comes!" For thirty minutes, this woman was kept under deep anesthesia. Finally the doctor arrived and, after the patient was allowed to come out of the anesthetic sufficiently to recognize and speak to her doctor, she was again anesthetized. He performed a deep episiotomy and delivered the baby from the unconscious woman by forceps. Uterine inertia, a severe hemorrhage and, a day or two later, infection caused this mother to pay a terrible price in suffering, lack of vigorous health, and cash for many months.

If I were to ask a group of obstetricians: "On the basis of the facts I have given, do you feel it would have been better to deliver that baby than to strap the patient's legs together and anesthetize her for half an hour?" I am sure of their answer. They would chorus, "Yes, it would have been better to deliver her!" I am sure that if each of you should ask the obstetrician whom you work with and trust the same question, his answer would be, "Yes. If it were my wife or my baby, I would want the delivery to take place. It is good practice!"

This situation represents a clash not between the doctor and the nurse but rather a clash between two nurses—one standing for the *status quo*, the

system regardless of its effect upon the health of a mother and baby, the other standing for good care which puts the mother and her baby at the centre.

As I pondered the question, which some people would file under ethics, I turned to the *Century Dictionary* to find out just what it says about a nurse, and the definition is: "One who nurtures, trains, cherishes or protects." I found myself asking who that nurse was protecting, cherishing, nurturing, training? Now I leave you with the same question to ponder, but I will ask you another: What should she have done? Let us assume that in the first place the supervising nurse would not have been there had she not been trained to attend a normal patient and deliver her if necessary. And, since she was trained, should not her prime consideration have been the woman and the baby and shouldn't she have delivered her? I would say yes, a thousand times yes! Any rule which makes that course impossible is a rule to be broken—broken not behind a closed door but out in the open. Now had the sister of the

patient insisted upon this, there would have been a clash of opinions and of authority.

Should she not have said, "I refuse to let you hold back the baby!" Only by such willingness to stand for what is right in terms of the life and health of the people we serve can nursing make its greatest contribution to medical progress. Remember, the world does not go forward with the unreasoning conformists but with the people who have the courage and imagination to do the things they believe are right—yes, even to breaking the rules!

I would remind you that a nurse named Nightingale, a nurse named Kenny, a nurse named Cavell, a nurse named Sanger, had the courage to break the rules—and make the rules—in the interest of the people they served. It is through these people and many others like them that nursing has gone forward. And so we find ourselves in a changing world—no, in a changed world—and we have many changes yet to make in our profession if we are to carry the lamp—brightly burning!

Criticism

No one really escapes criticism and the more eminent one is the more criticism may be expected. That is a price one pays for holding a distinguished position. It is as Addison said in his essay on *Censure*—"Folly to think of escaping it and weakness to be affected by it." There is no defence but obscurity.

Fair criticism implies a desire on the part of the critic to judge with clarity and say with honesty what he believes to be true. His judgment will be based upon his own experiences, his disappointments, his burned fingers, and his beliefs. At the same time, he will make an effort to get the other fellow's point of view and take the gentle and indulgent side of most questions.

Fair criticism does not judge without factual information. It considers the event on which it is to pass judgment in the light of these factors: what was said or done? what did the person mean to say or do? what was his reason for saying or doing it?

what is the effect of what he said or did? why do I object to it?

If we are on the receiving end of criticism, we must school ourselves to rise above all that is petty and to accept and use what is worthwhile. There are times to fight back but these must not be decided by inclination but by answering the question, after searching consideration of the criticism: Is it right?

—*Royal Bank Monthly Letter*

Christmas

It is an old *Irish* custom to place a candle in the window on Christmas Eve to light the Christ-child on his way and the use of a candle appears in many other lands and in many different ways. In *Armenia* myriads of candles are used in the Christmas celebrations and in *Czechoslovakia* tiny candles are set upright in nutshells and floated in pans of water.

Nurses' Part in a Prenatal Program

KATE MCILRAITH

Average reading time — 10 min. 24 sec.

THE AIM OF a maternal hygiene program should be a healthy woman giving birth to a healthy full-term infant and making a satisfactory return to her normal vigor so that she may enjoy to the full her function of mother and homemaker. Carolyn Van Blarcom has stated that the nurses' part in a program for prenatal care is:

To assist the doctors in carrying out the prescribed details of supervision, instruction, and care of expectant mothers, and to work toward the ideal of having every expectant mother in the land under medical care from the beginning of pregnancy.

There is need for a well developed team-work between the nurse and the doctor. The nurse's visit does not take the place of medical supervision but is rather an interpretation of his orders for the health and well-being of the expectant mother. It is essential also to enlist the interest of all workers in the field of health and welfare and of the general public. What we must remember is that the ideal we are striving for is not that the high peaks of obstetrical care shall be higher but that *the average care given to all patients shall be raised*. This means getting every expectant mother under care and then making that care so satisfactory and effective that it will benefit her and the baby.

Today every woman's magazine and almost every daily paper feature frequent articles on maternal care by well-known authorities. Unfortunately, only a small proportion seem to avail themselves of this method of improving their knowledge of this subject. We must realize that all pregnant women are not alike in their intellectual capacity. We know that some can be taught more about

health than others who may be equally interested. The nurse must learn to suit her method of teaching to the mental capacity of the patient. In some cases she will need all the information she can acquire to satisfy the patient's intellectual curiosity. In other instances, she will need to teach one idea at a time and even that one idea may have to be repeated on many subsequent visits. For the latter patient, the nurse demonstrates each subject she brings up, perhaps by the use of actual materials, perhaps merely by sketching with pencil and paper in order to reach the patient through other means than the spoken word.

In addition to differences in mental capacity, every nurse knows the effect of variations in background of the patients—racial, economic, etc. The important thing to remember about adequate maternity care is that not enough people know what it is in all its elements and not enough are putting into practice what they do know. This is as true of nurses as it is of doctors and layman. Yet if there is one field in nursing that demands a combination of knowledge, skill, and common sense, it is the maternity field.

In addition to an all-round fund of knowledge and skill, the nurse must have the ability to impart this information to others. She needs a genuine interest in what she is teaching, in the people she is teaching, as well as an understanding of teaching methods and of human psychology. In other words, what she does with her equipment of theories, facts, and skill is more important than her mere possession of them.

There are great individual differences between patients in personality, in character, and in maturity. The study of these personality differences is essential in each family with which the nurse works. The reactions and

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attitudes of the patient are a definite part of any home situation. The real test of the nurse's knowledge of maternal care is reflected in her patient's activities and reactions and those of the whole family.

The nurse has a vital responsibility to the community. The magnitude of this obligation cannot be overestimated since widespread prenatal work cannot be carried out successfully without the whole-hearted support of nurses. To demonstrate her full support and interest in this work, the nurse must be not only familiar with what constitutes adequate prenatal care, but she must be so imbued with enthusiastic interest that it will spread not only to her patients but to the community at large.

Expectant mothers may be reported to the nurse by the patients themselves, by doctors, hospital clinics, social workers, and other health workers in the field. It is not enough for the nurse to wait for patients to seek her help—she must seek the patients.

Periodic and regular visits by the nurse to the various doctors' offices make for an excellent relationship and ensure a better understanding and cooperation in this work.

Prenatal teaching may be carried out in classes for expectant mothers or by visiting in the patient's own home. Both have their advantages, depending upon the individual patient. Classes are stimulating and provide a better opportunity for discussion, a wider scope for demonstration and the use of the many teaching aids available.

The young mother of average and above-average intelligence who is expecting her first baby is the one who finds the classes most helpful. The mother with other preschool children does not find it easy to attend classes so that home visiting is more helpful to her. The mother whose intellectual capacity is limited also is assisted better when the nurse sits down in her own familiar setting and discusses one simple idea at a time.

The nurse's duty to the patient

might be said to be: (a) watching or supervising; (b) teaching; (c) sustaining or giving moral support.

The nurse has an opportunity to observe the patient carefully between the doctor's consultations with the patient and to report to him. She can sift through the symptoms and give him a detailed report. Such symptoms as headache or dizziness may be significant of some complication or merely faulty health habits, fatigue, which in itself may be alarming or merely indicative of inadequate rest. The visits by the public health nurse can be as frequent as seems necessary, depending upon the physical condition of the patient, her mental attitude, and the need for instruction.

The starting point with each patient is based on what that patient knows about maternity and her ability to absorb further knowledge. The average woman needs to know why rest, good diet, exercise, and medical supervision are important to her and her baby. She needs to realize that her baby is nine months old when he is born. Once she is established on a routine of rest and exercise and understands the need to follow the doctor's instruction, that part of the teaching can be curtailed and other matters stressed. She may require little or much help with her diet which is, of course, the one advised by her physician and based on her particular needs. The amount of help she requires in planning it will usually be determined by her economic status, her intellectual level, and the amount of adjustment that is necessary.

Plans for her own clothing and that of the coming baby are usually easily made. If the mother fully understands the changes taking place in her body and the growth of the baby she will more readily understand the need for good body mechanics and the relationship to comfortable well-fitting clothing and shoes.

The birth of a baby is not purely a physiological process. There are emotional factors which are all too frequently forgotten. The whole woman—her mind as well as her

body—is involved. No pregnancy is routine. While it is true that each woman reacts to pregnancy in her own way, many of the experiences met with are sufficiently similar to produce certain recognizable reactions in the pregnant woman. Three of these are: (a) certain emotions attendant on bodily changes; (b) fear, in various manifestations; and (c) the reactions of the family to the mother's condition.

Physiological changes carry their accompanying emotional reactions. At the onset of pregnancy there is an increased activity of metabolic functions, requiring a rebalancing of the mother's physiological activities. If balance does not result, the patient may become toxic. This, in turn, is closely associated with mental irritability and depression. Little worries seem magnified and the patient may feel like a creature in a trap. She may resent her pregnancy. This is no time for the nurse to take too seriously what the patient regards as her troubles nor should she try to be convincing regarding the beauties and joys of motherhood. She should take the role of listener, letting the patient talk it out, so to speak. Perhaps on the next visit the complainant will be more serene and emotionally receptive to thoughts of the future and planning for the baby's coming.

A common reaction to pregnancy is fear—fear of death, of labor, of marking the baby, to mention only a few. Very often these patients do not admit their feelings to the family or even the doctor—sometimes, indeed, not even to the nurse. The nurse's attitudes, her sympathy, and understanding will do much to clear

up these difficulties. Fears, worries, and feelings of inadequacy are not conducive to peace of mind and emotional balance.

The reaction of the expectant father towards his wife is important. His help and understanding cooperation are vital. If there is an older child it is essential that he, too, should know of the coming baby. Telling him of this expected addition not only provides an excellent opportunity for sex teaching but it will help the older child to welcome the new baby into the family circle. Without previous preparation it is often difficult for him to learn to share the love and attention of his father and mother with a new-comer.

It is important that the expectant mother should understand *how* a baby is born. When she knows how labor begins and progresses, what is actually happening when she feels her uterus contracting, what to do, what will be done to her and why, labor becomes not a dreaded ordeal but "one of life's most interesting experiences"—a marvelous provision of nature for bringing her baby into the world safely. Without this understanding, the uncertainty, the fear of impending pain or disaster, which are traditionally implanted in the minds of most women, keep her tense and anxious and disturb the neuromuscular harmony of the mechanism of labor, prolonging the whole process, causing unnecessary pain and leaving emotional scars.

Teaching mothers about labor does *not* frighten them. On the contrary the well-informed mother anticipates her baby's birth, calm and unafraid because she knows what to expect.

Christmas

It is not known with certainty when the festival of Christmas was first celebrated. It is spoken of in the beginning of the third century in the writings of Clement of Alexandria. In the latter part of the fourth century a writer speaks of it as of great antiquity. There was considerable diversity as to the day on which Christmas was celebrated until the fourth century when the Western

Church fixed on December 25 as no actual knowledge of the day of Christ's birth existed. The Eastern Church had favored January 6 but gradually adopted the same date. A heathen festival of early Rome, the Brumalia, which was held at the winter solstice when the sun is, as it were, born anew, has often been mentioned as having had a strong bearing on the selection of the date.

Prenatal Classes in Greater Toronto

CONSTANCE GRAY, B.A.

Average reading time — 9 min. 48 sec.

THESE CLASSES now appear to be well established, an accepted part of the community health program in Greater Toronto. The sponsorship of the cooperative planning for these is unique. The Welfare Council of Greater Toronto in 1944 undertook, in its Division on Health, the job of coordinating the efforts in prenatal education of the health agencies in the community. This was at the request of the agencies since they felt the need of a unifying force to guide and support this project in prenatal teaching.

The Welfare Council appointed a volunteer chairman and has provided a very substantial amount of secretarial help, as well as assistance in securing considerable newspaper publicity, an item that has been found to be essential.

A Policy Committee, composed of representatives from the health agencies, was formed to help with the shaping of policy, over-all planning, and matters of budget. This committee then appointed a Working Committee to take care of the arrangements connected with the operation of the classes.

PLAN OF ORGANIZATION

As a result of these efforts three centres were opened in the east, north, and west parts of the city. The history has been one of steady growth and expansion. At present there are 11 classes, eight of which are distributed over the city and the other three in the outer metropolitan area in Etobicoke, Leaside, and East York. The classes are held in churches, Y.W.C.A., hospitals, and libraries—

wherever a suitable and accessible location can be found. The total number of young mothers in the community who have attended these classes is now approximately 4,000.

The original group of community health workers were the public health nurses (the Toronto Department of Public Health, the Victorian Order, and the St. Elizabeth Visiting Nurses) and the Visiting Homemakers. To these have been added the Etobicoke Department of Health, the East York-Leaside Health Unit, and librarians from the public libraries. There is a field of service here, too, for the Red Cross volunteer who attends every class and helps with the registration of pupils, the demonstration of the baby's layette, and the serving of refreshments. The custom of providing tea has value far beyond the merely physical business of eating for it is during this informal period that many of the vital and troublesome (to the pupil) questions are brought out. The friendly contact with the teacher and with other young women facing the same hope does much to dispel the feelings of isolation, loneliness, and fear that every mother experiences at some time during her first pregnancy. The librarian attends one class in the series and brings with her a book display on relevant topics such as prenatal hygiene, infant and child care, and books for the young child.

The budget is a matter of considerable importance for any sustained effort of this nature and deserves some thoughtful consideration. The participating organizations that began in 1944 with a small budget for three classes now operate and finance 11 classes. Each agency contributes approximately in proportion to the number of teachers it provides. Three items are of interest: \$70 covers the cost of the layette which includes a

Miss Gray is consultant for maternal and child hygiene with the Toronto Department of Public Health. An earlier article, describing these classes, was published in our February, 1948, issue.

Birth Atlas (New York Maternity Centre Association); \$10 provides the refreshments for a series of 10 lessons; \$1.00 per class ensures adequate caretaking services.

CONTENT OF TEACHING

On the basis of several previous experimental efforts with a longer series, the Welfare Council began its classes with 10 lessons. This plan has remained unchanged to the present although the content of the teaching has been altered, revised, and reorganized from time to time. The Working Committee has provided a guide of teaching material for the teachers to help them and to ensure a reasonable uniformity for the classes. This material, which has been approved by the Departments of Obstetrics, Pediatrics, and Psychology at the University of Toronto, has recently been published in booklet form and may be purchased from the Welfare Council. [See *Between Ourselves*, p. 940 this issue.]

The public health nurses teach seven of the 10 classes, the nutritionist from the Visiting Homemakers teaches two. Both teachers share in the initial class. This first one is a general introduction, explaining the purpose of the classes, the sponsoring group, and the participating agencies. The major emphasis is placed on "Foods for Health" since diet is such an important factor influencing the expectant mother's health. This is thought also to be the best class for the librarian from the local branch to attend as the pupils are interested in having the information about the library facilities in order to prepare for the rest of the lessons of the series. It has been found a practical plan to have the librarian speak at the close of the teaching hour, as the discussion of books can be conveniently carried on into the informal refreshment period.

The second class deals with the anatomy and physiology of pregnancy and is called "How the Baby Grows." This is a class that presents much new material to the mother and the *Birth Atlas* has been found to

be a very helpful teaching aid.

Classes three and six are taught by the nutritionist. She discusses the normal diet and the changes required in it during pregnancy, the nutrient value of foods, and the influence of diet on lactation. This is called "Foods for You and the Baby."

The fourth, fifth, and seventh classes include the teaching of the hygiene of pregnancy. Here the mother gains an understanding of the relationship of physical and emotional reactions during pregnancy as well as the value of good hygiene. One of these classes is devoted to breast feeding, for it is hoped that these young women will all enjoy this privilege of motherhood through better preparation and better understanding of its psychological values. In these classes there is an opportunity to discuss the "old wives' tales" that every expectant mother hears, and the worries and fears that each one has.

Class eight deals with the baby's layette, a subject where discussion is always lively, and class nine draws the largest attendance of all the classes. This is the baby's bath.

The last class is called "Off to a Good Start." Its content is designed to help the new mother assume her responsibilities with confidence by preparing her for the problems she is likely to meet on her return home from hospital.

Two months after the expected date of confinement, a questionnaire is sent to all pupils who have attended more than one class. Approximately 43 per cent of these questionnaires are returned. It is interesting to note that the usual return on a general questionnaire is only 15 per cent. Our results would seem to indicate a keen interest on the part of the pupils. Needless to say, the mothers enjoy the opportunity of helping with suggestions for changes or improvements in the teaching content. These questionnaires have been an excellent means of evaluating the needs of the pupils and the efficacy of the teaching. In accordance with these findings, the content of the

teaching material has been changed and enlarged and the methods altered.

GENERAL OBSERVATIONS

There are some general observations that can be made about these classes that are of interest and significance. They raise new questions and problems in this vital field of education.

The appeal of the prenatal classes has been to a group of young women who are intelligent, informed, of average economy, and who are receiving their medical care from private physicians and obstetricians. These impressions, obtained at any class, may be verified from information on the registration cards. This picture has been consistent over a period of six years. Classes tried in the poorer areas of Toronto have had to close for lack of pupils in spite of the fact that clinic patients have been referred to them in various ways. If these mothers do attend one class they usually fail to return. This problem of reaching the clinic patient is one which might be studied with profit. From every point of view they have a need for this teaching although they do not respond to the invitation of these classes. One may be reasonably confident that these mothers have as strong an interest in their babies as those who do attend. Would some adaptation of these classes or some other method of prenatal education be more effective? It seems unlikely that one set pattern of prenatal education will ever meet the needs of a city with a population as diversified as that of Greater Toronto. With these needs in mind, the committee is formulating plans for a modified series.

Another feature of these classes is the fact that the pupils are almost invariably primiparas. There were 808 of them out of a total of 871 in the season 1949-50. The remaining group of 63 pupils were made up of multipara and the occasional grandmother, anticipating responsibility for a new baby, or perhaps a mother who planned to adopt a child. The reasons for such small numbers of multipara

attending these classes has occasioned some concern. This may be a matter of baby-sitting or perhaps is due to a feeling that they do not need any further instruction. If the problem should be the former, the solution is obvious and might be explored fairly easily; if the latter, it would be more difficult to assess and overcome.

Publicity has been a very important consideration. Newspaper publicity especially was felt to be essential for the attendance at the classes varied directly in proportion to the amount of it. In 1946 this type of publicity accounted for the largest number of pupils attending the classes. In 1950 we observe that friends and relatives (usually former pupils of the classes) are the best source of referrals. Physicians, who were in about fourth place when the classes began, have now become the second best source of pupils. This has been a gradual change and we may anticipate the time when the physician will be the first source of referral.

There are many other practical problems such as how to secure fresh teaching material, new ways of using the old material, the best method of preparing the nurse teachers, the value of teaching aids, the use of films, etc. The place and function of the volunteer is a matter that has been considered thoughtfully and reviewed periodically in these classes. It has been difficult to hold volunteers. Is it because their responsibilities are not sufficient and, if so, how can they be increased or their duties made more interesting?

Looking into the future we anticipate an increased need and demand for these classes. It might be noted here that the number of young women taking advantage of these classes is about 5 per cent of the total number of births—that is, the possible total of expectant mothers. This would indicate that there is still a large field for the expansion of prenatal education. The steady rate of increase in attendance would seem to substantiate this, as well as the fact that early ambulation and short hospitalization periods are now features of ob-

stetrical practice that probably are here to stay. When the new mother returns to her home her problems are manifold. Breast milk is not established. Usually the umbilical cord is not healed. Perineal care may still be required. The responsibilities for the care of the new baby loom large and serious when there is no competent hospital authority nearby to

help with them. Adequate preparation and planning for these difficulties during the prenatal period will do much to eliminate them. This is in accordance with the newer thought of "anticipatory guidance," recognized as sound practice in the field of public health. That a child be "well born" is the prime requisite to a good start in life.

Nourishment for a Pregnant Woman

LUCY RANDOIN

Average reading time — 2 min. 43 sec.

IT SHOULD NEVER be overlooked that the life of a human being commences long before birth. The first nine months of its existence, passed as a "parasite" as it were in the mother's uterus, have a very considerable influence over its whole life.

Too many expectant mothers, happily preparing cradle and layette for the child, overlook the fact that, according to the manner in which they are being nourished, they will give birth either to a splendid baby or to a sickly, rickety creature, which will have to bear during its whole life the consequences of prenatal negligence.

It is, therefore, specially important that an expectant mother should carry out simple rules, more especially as from the fourth month of pregnancy.

1. Case of a pregnant woman, in good health, presenting no trace of albumin:

What not to do: Do not try to eat the largest possible quantity of very nourishing food, more especially starchy foods: rich bread, macaroni, dried vegetables. A pregnant woman who eats too much puts on weight and runs the risk of losing her suppleness which is indispensable if her delivery is to take place under good conditions.

Do not try to consume large quantities of fatty foods, as the milk which must be

taken each day by a pregnant woman already supplies this need. An excess of fats fatigues the liver and the kidneys which are particularly fragile during pregnancy. For the same reason, avoid cooked fats.

Do not make an excessive use of such meats as liver, heart, kidney, sweetbread, etc.

Do not make a frequent or regular use of stimulants: coffee, tea, salt, pepper, and other spices.

Drink moderately during meals.

What to do: Eat every day a sufficiently large quantity of foods rich in calcium so that the baby shall not be born rickety and the mother's teeth and bones shall not become decalcified. These foods are, more especially: milk (whole or skimmed), all kinds of cheese (fresh or fermented and made from either full cream or skimmed milk), and yoghurt.

At the two principal meals take a sufficient quantity of fresh vegetables (particularly green vegetables) and, if possible, fresh fruit in order to:

(a) Combat the danger of constipation which lies in wait for pregnant women and may provoke liver and kidney trouble.

(b) Bring to the organism abundant quantities of the mineral matter and vitamins which are absolutely indispensable for the development of the fetus.

Fresh *raw* vegetables (tender green

salads, grated cabbage, grated carrot, grated turnip, celery, radishes, olives, etc.,) should be eaten every day for they have the maximum vitamin content.

If possible, in spite of high prices, take oysters from time to time.

2. *Case of a pregnant woman, presenting traces of albumin:* The advice given above should be followed but it is indispensable

to avoid taking any sausage or similar products, shellfish, eggs, or heavily salted or spiced commodities whatsoever.

The consumption of meat and fresh-water fish is permitted.

3. *Case of a pregnant woman showing marked albuminuria:* In such a case a doctor must be consulted; he will indicate the regime which must be followed.

Towards Easier Childbirth

JOSEPHINE BARNES, M.D.

Average reading time — 4 min. 6 sec.

THE ENDEAVOR to relieve the suffering of women in childbirth dates back many centuries before the modern era of anesthesia. Before discussing the advances of recent years, however, it is essential to mention the new conception of the conduct of childbirth introduced by Dr. Grantly Dick Read and his followers. This centres around the idea that natural childbirth is not a painful process but that in the cultured woman the emotion of fear tends to lead to tension which of itself results in pain. The modern tendency is, therefore, to urge the mother to train herself for childbirth by the practice of relaxation, by exercising the special group of muscles that will be used, and by learning special methods of breathing which will permit her to have her baby in complete consciousness but without undue suffering. These methods are being widely practised throughout Britain and are also beginning to be used in the United States and Canada.

VARIETY OF AGENTS

For the mother who does require relief of pain in childbirth a bewildering

variety of agents is now available. The most powerful pain-relieving drugs, however, are dangerous to the baby as they tend to prevent the infant from breathing normally after birth.

Childbirth can be divided into three main stages: the first—the passive stretching of the maternal passages to permit the birth of the baby; the second—the stage in which the mother, by powerful muscular efforts, expels the baby from her body; and the third—during which the placenta is delivered.

For the first stage of labor, which may last up to 24 hours in a normal first birth, the chief needs of the mother are for sleep and relief of pain. For this stage sedatives such as chloral hydrate, to ensure sleep, and pain-relieving drugs or analgesics are required. Until recently morphine and other derivatives of opium were widely used but these have now been largely superseded by synthetic analgesics which are less dangerous to the baby. Foremost among these in modern obstetric practice is the synthetic drug pethidine which was discovered in Germany in 1939. A great deal of research in Britain and America, where it is named "demerol," has established it as one of the safest and most powerful of all the analgesic agents used in childbirth. Unfortunately, the occurrence of cases of

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addiction to demerol made it necessary to control its sale and it is at present only available to mothers in Britain under a doctor's prescription, though a midwife is allowed to give it when acting on instructions from a doctor.

TWILIGHT SLEEP

The term "twilight sleep" is applied to a method of relief in childbirth which includes the use of hyoscine with a pain-relieving agent, originally morphine. By this method not only pain but the memory of pain is abolished from the mother's mind. The great disadvantage of this method, however, is that the mother's cooperation is often lost and delivery by instruments becomes necessary. Also the baby may be born in a condition of asphyxia. A modification of "twilight sleep," combining demerol and hyoscine, has been successfully and safely used in the United Kingdom and America. But demerol is certainly not the last word in pain relief in childbirth; research is continually going on to produce something even safer and more effective.

Later in the first stage and second stage of labor, the needs of the mother alter. She now requires a powerful analgesic which operates intermittently—that is at the height of the contraction of the uterus or "pain." At this time an analgesic which is inhaled by the mother and which she can administer to herself is best. For this the well-known "gas and air" method, invented by Dr. R. J. Minnitt of Liverpool, is widely used, especially as a midwife working alone can use it, provided she has received the special training required. The mother presses a rubber mask on to her face and inhales deeply from the machine which delivers a mixture of

50 per cent nitrous oxide or "laughing gas" and air. The mother cannot suffer from an overdose if the machine is properly used, since if she loses consciousness she releases the mask.

A notable United Kingdom discovery in recent years has been that of trichloroethylene or "trilene." This is a powerful anesthetic, similar in many of its actions to chloroform, and it can be used as a self-administered analgesic for childbirth in a similar way to nitrous oxide.

As a result of a recent trial carried out by Britain's Royal College of Obstetricians and Gynecologists, it was decided that trilene could not be considered safe for the single-handed midwife to administer with its present appliance, as overdosage could result from a change in temperature or from shaking the bottle which contains the liquid trilene. It is probable, however, that current research will shortly solve these difficulties. Trilene is much more portable than gas, which has to be carried in heavy cylinders. It is also non-inflammable.

A committee set up by Britain's Medical Research Council is at present considering the problem of pain relief in childbirth from the standpoint of the midwife and with special reference to the mother who is having her baby at home. Research is being carried out into new drugs and new methods and, though the results are not likely to be available for some time, it is hoped to bring adequate relief within reach of every mother wherever she is confined.

It must be realized, however, that no universal panacea for pain in childbirth exists or is even likely to be discovered. In future it is probable that greater emphasis is likely to be given to natural childbirth and thus lessen the need for artificial relief.

Christmas

The star is a universal symbol—used in many countries. In *Poland*, for instance, Christmas dinner is not served until the evening star shows in the heavens, while from *Alaska* comes an especially interesting

custom called "Going Round with the Star." A star-shaped wooden frame is covered with bright tissue paper and for three nights prior to Christmas it is carried from door to door by carol-singing boys and girls.

Nurses' Part in Postnatal Care

HESTER LUSTED

Average reading time — 8 min. 12 sec.

THE AIM OF all postnatal care is twofold: first, to ensure the satisfactory return of the mother to her normal health and vigor; second, to ensure adequate care for the newborn infant so that he may develop normally, remain free from disease, and establish satisfactory behavior patterns. We must recognize the importance of each of these distinct yet interrelated aspects of the situation if we are to achieve good postnatal care for every mother.

In considering the nurse's part in postnatal care we tend to think of the actual physical care required by mother and baby as the primary need. Actually the fundamental factor is the many adjustments which the mother must make during this period in order to successfully do her combination job of mother, wife, and homemaker. There is no more critical period in family living than the days and weeks immediately after the birth of the baby, particularly a first baby; and no greater opportunity to demonstrate how invaluable good nursing care can be to the patient, the physician, and to the entire community.

Skilful professional care can aid mother, baby, and father so that family ties are strengthened during the postnatal period and the ideal result achieved—a healthy baby with a strong sense of security developing desirable habits and by his contentment reflecting a harmonious home atmosphere with happy parents.

Our part as nurses is to act as a connecting link between physician and family and to assist the mother: (1) with her own care; (2) with the care of her baby; (3) in making the necessary adjustments in her way of

living so that the care of the baby can be accomplished without disrupting the entire household.

Many young mothers find it extremely difficult to make these adjustments. It is not uncommon to find that by the time the baby is three weeks old the entire family is upset. The house is untidy, the baby cross and irritable, the mother distracted and tired to the point of exhaustion. There is no plan for any of the daily activities and everything centres about the baby who has developed into a small tyrant. Such an experience can be avoided if the mother realizes the importance and value of a planned routine for her day's work. Where she has had good prenatal supervision she will have learned what the baby's care entails and will know the necessity of having a daily schedule; but without help it takes time to get even carefully made advance plans into operation.

Postnatal care starts before the mother leaves the hospital or is up and about in her own home. She should be taught, following the doctor's orders, to do the few simple exercises that will strengthen the abdominal muscles. In addition she must be warned of the dangers of over-exertion. It is not too early to start talking about how she will manage when she again assumes her place as head of her household. The fact that the mother nowadays is allowed on her feet shortly after delivery may give rise to the erroneous impression that she can immediately return to full activity. This should be avoided by definite plans for help with the essential housekeeping tasks from husband or relatives, or hired household help, so that the mother can care for her baby herself and still get sufficient rest.

Naturally the mother's first concern is the welfare of her baby and

Miss Lusted is second assistant superintendent at the National Office of the Victorian Order of Nurses for Canada.

she feels that the first big task she faces at home is his daily bath. If she can have the best possible nursing assistance at this point many of the difficulties and complications of the later postnatal period can be prevented. Such nursing service may be given on a full-time or part-time basis but it *must* be given by a nurse specially prepared to give postnatal care, one skilled in teaching and counselling.

It is not suggested that only a nurse can give the baby a bath but the skilful nurse uses this occasion as a demonstration of the easiest method of bathing and dressing the baby. As soon as the mother wishes, and feels strong enough, she bathes the baby herself with the nurse present to guide and encourage her in learning this new skill. The nurse should not consider her care to mother and baby adequate until she assures herself that the mother can handle the baby with assurance and to the mutual satisfaction of both.

To the mother the bathing of the baby is the outstanding accomplishment during the first few days at home. To the nurse the vital point is the opportunity it gives her to establish a good relationship with the mother and advise her concerning innumerable details of the baby's daily routine and her own health. The well-qualified nurse anticipates many questions of which the mother is hardly aware and, by teaching her something of the development of the baby, prepares her to handle each new situation as it arises.

What does the inexperienced mother know about nursing her own infant? Someone should teach her very carefully the first time the baby goes to the breast or she will feel bewildered and frustrated with a consequent poor effect on lactation. If she knows that her baby only gets colostrum at first, that it acts as a laxative for him and that, until the milk supply is established, he should only nurse a few minutes to stimulate the breasts, she is prepared to enjoy this new experience.

Another important point is to teach her how and why her nipples

should be protected from infection. The period of engorgement should be explained and that the baby may have difficulty grasping and sucking the nipple when the breasts are firm. Most new mothers think that at this stage they have too much milk—if they realized that they probably secrete less than eight ounces they would not feel discouraged or alarmed that the baby is not satisfied with breast alone. Often a supplemental feeding is prescribed without explaining to the mother the best method of using this. Without her understanding, it soon acts as a substitute. She may have no knowledge of the many ways in which milk can be stimulated; if, in addition, she believes that a baby only cries when hungry she will answer this "demand" with more food and before the 10th day the baby will be weaned and her breasts never have a chance to work up to that daily 16 ounces that is normal by the 10th day.

So often we hear a mother say, "I tried so hard to nurse my baby but after the first week or two I had to wean him." If she understood how her breasts functioned would she consider the first week a fair trial? Between the 5th and the 10th day, when the milk supply can double itself, the mother is getting home with her baby, learning to care for him, and gradually increasing her own activity. Nursing care that is "caring" can help her make breast feeding a successful and satisfying experience instead of a failure.

Nursing care should not end after the first few days at home are successfully past. The mother needs periodic visits for supervision until she is able to take her baby out to the doctor's office or to a Well Baby Clinic. If she has had the V.O.N. service, weekly visits are made till the baby is six weeks of age. If other nursing service has been given periodic visits can be made by a nurse from the City Health Department. During these visits the nurse observes the health of the mother and baby and encourages the mother to practise teaching that has already been given. At each visit the

nurse guides the mother in handling new phases of the baby's growth and behavior.

The importance of the post-partum examination is emphasized for, if the mother is feeling well and has not been previously convinced of its value, she may neglect to return for this check-up. The nurse also stresses the value of medical supervision for the baby, either by a private physician or clinic. By explaining the need for immunization the nurse prepares the mother to expect this health protection for her child. The intelligent mother usually has many questions to ask regarding the growth and development of her baby and by giving her an understanding of normal processes the nurse helps to lay the foundation for a stable family life.

Most of these remarks have applied particularly to the mother who is a young primipara. If the mother is an older primipara these same problems of adjustment will likely be intensified because her pattern of living is well established without a baby. If husband and wife have been anxious for a child for a long period they may be so oversollicitous in their care as to upset the baby.

Where the mother is a multipara she returns to the responsibility of the other children's care. She may not need as much teaching regarding the care of the new baby but she does need help and a review of the latest methods. If the preschool children

have not been prepared for the new baby, she may have behavior problems to deal with and overt displays of jealousy. The nurse in bathing the new baby can do a great deal toward solving such problems.

As a member of a profession every nurse has a responsibility to the community in addition to her responsibility to her patient and to the physician, and this responsibility should include the promotion of adequate maternity care for every mother and potential mother in the community. The nurse herself may not be participating in a maternity program but even so she has many contacts with prospective parents in the course of her daily activities. These contacts provide opportunities to inform them regarding safe and adequate maternity care.

Generally speaking the public places unlimited confidence in a professional nurse and if we are to demonstrate that such confidence is not misplaced we must keep ourselves well informed and alert to provide information.

At the very least every nurse should know where the patient can get the service she needs, whether this service is provided by hospital or by public health organizations. It is our responsibility to educate the community to make full use of the available facilities for nursing care. This is only possible through full cooperation between nurses in all fields.

Canadian Red Cross Society

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia—APPOINTMENTS: *Mrs. Jean Haines* (Royal Columbian Hosp., New Westminster) to Edgewood. RESIGNATIONS: *Edwina Buchan* from Edgewood; *E. Floren* from Terrace to be married; *Mrs. Jane Spencer* from Lillooet.

Ontario—APPOINTMENTS: *Dorothy Chapman* to Armstrong after taking public health course. TRANSFERS: *Oda Hansen* to Hornepayne; *Mildred Harton* to Mindemoya; *Amy Hayward* from Nipigon to Richard's Landing;

Winona Inches from Emo to Bancroft; *Madge McFarlane* to Englehart; *Peggy Parker* from Emo to Rainy River; *Margery Rilett* from Port Loring to Kakabeka Falls; *Helen White* from Dryden to Nipigon. RESIGNATIONS: *Eulalie Brown* from Emo to go to University of Toronto; *Barbara Chrysler* from Richard's Landing to be married; *Ruth P. Gillies* from Haliburton; *Dorothy Hall* from Dryden; *Gaelane Larocque* from Apsley to go to University of Ottawa; *Wilma Lippert* from Matachewan to be married; *Mary Nickel* from New Liskeard; *Mrs. Lucy Shaw* from Huntsville; *Ella Sommerfeld* from Apsley.

Breast Feeding

HILARY B. BOURNE, M.D., C.M.

Average reading time — 9 min. 36 sec.

THE PURPOSE of this article is not to convey any particular scientific data but rather to remind members of the nursing profession that breasts were supplied for the specific role of suckling the newborn.

The first visible evidence of the formation of mammary glands is recognizable in embryos during the second month of development. It is usually during the sixth week that a pair of band-like thickenings make their appearance along the ventrolateral body-walls from the axillary to the inguinal regions. These are the so-called "milk lines" and it is from these that the mammary glands arise. In the human species the mammary glands as a rule develop within rather narrow limits of the pectoral regions, but not infrequently supernumerary nipples may occur at other levels along the course of the milk lines.

Histologically and developmentally, the mammary gland suggests somewhat a sweat gland. In the resting stage each gland is composed of 15 to 25 closely adjoining, irregular lobes radiating from the nipple. These are separated from one another by layers of connective tissue and much fatty tissue. Each lobe is provided with a duct, the "lactiferous duct," which runs towards and opens on the nipple. Each duct under the areola, the pigmented area surrounding the nipple, has a local dilatation, the "lactiferous sinus," which becomes constricted again and, curving upwards towards the surface of the skin, opens at the summit of the nipple as an independent opening. In essence, the mammary glandular tissue may be likened to a bunch of grapes with the grapes being the secreting por-

tions and the stems representing the duct system. In between the grapes and stems lies the connective tissue and the quantity of fatty tissue which is responsible for the contour and great bulk of the breast. It is easy to realize, therefore, that the size of the breast gives no indication of the amount of glandular tissue.

The physiology of the mammary glands is interesting but complex and as yet not clearly or definitely understood. Suffice it to say, however, that the ovarian and pituitary gland hormones seem to be responsible for its development to full maturity and functional activity while the stimulation of the nipple produced by the act of suckling creates a reflex nervous mechanism that maintains the secretory activity.

It is a well-known fact that the worst place in the world as regards breast feeding is the United States; Canada runs a close second. It is also well known that the European, and in particular the Scandinavian, countries are best in this regard. The difference, however, is not due to geographical location, or anatomical development, or even physiological insufficiency. The great difference is one of temperament, education, and so-called modern living. The North American woman of today is not sufficiently impressed during her adolescent years of the importance and advantages offered by breast feeding. She is rather inclined to think the opposite because all her older friends who are married and new parents are using the bottle and one of the many powdered milks which are so beautifully advertised in journals—medical and otherwise. Moreover, she does not have time to breast feed and, in particular, she is unable to go to the movies or social functions because she has to be at home at the time of the next feeding. There are a

Dr. Bourne is a physician in the Department of Obstetrics and Gynecology, Royal Victoria Hospital, Montreal.

multitude of other reasons put forward by our women of today. We, however, must not confer the entire blame on the "mothers." We as doctors are also partly responsible. We are far too lenient in our efforts to convince the antenatal woman that she should at least have a try at breast feeding when the baby arrives.

Breast feeding is the natural way to feed the newborn infant. Nature made this provision purposely and also arranged for the production and flow of colostrum during the first two or three days after delivery, superseded by milk. The function of colostrum is apparently twofold: (1) To act as a catharsis and thereby free the alimentary tract of meconium, and (2) to provide a source of euglobulin, the only protein that newborn babies do not have in their blood and the protein which is associated with antibodies. These protective antibodies are, therefore, transferred from the mother in high concentration and accordingly afford the baby a better capacity to resist infection in early life. This may be the all-important reason why infant mortality is lower among successfully breast-fed infants. Famulener in 1912 said that it is most highly desirable that every newborn infant should receive its full ration of human colostrum.

The milk which eventually replaces the colostrum is well known to you both physically and chemically and is specially suited to the needs of the baby. Apparently human milk changes somewhat in composition as time goes by and the baby becomes older. There is no substitute for human milk. We can, however, approximate it very closely and with artificial feeding achieve wonderful results. But all of us are agreed that artificial feeding should be resorted to *only when natural breast feeding is a complete failure*. If the mother can supply as much as half the baby's requirements, then it is worth both the time and trouble to breast feed and supplement. Not only does the baby benefit but also the mother. It is well recognized clinically that the return to normal anatomical

size and position of her pelvic organs is greatly facilitated by the act of nursing. This is apparently a reflex nervous phenomenon originating in the nipple.

The success or failure of breast feeding depends to a large extent on the quality of the antenatal care. By this, I mean, that the doctor should not think of the pelvic organs alone and leave the breasts to the charge of the nursing staff. Instead it should be his bounden duty to impress upon the patient, particularly if she is a primipara, the importance of caring for her breasts throughout her pregnancy and the undoubted good which her baby will obtain from nursing. One must appeal to the emotional or, perhaps more correctly, the maternal instincts of the new mother-to-be and prepare her mentally so that by the time the baby is delivered she accepts the idea calmly and rather looks forward to the nursing. That the emotional reaction of the mother will govern in part the degree of success or failure of nursing is well shown in cows which, if disturbed emotionally, will desist from giving their usual abundance of flow. The patient should be instructed to pay particular attention to the nipple area and should the physical examination reveal any abnormality of the part, such as inversion, proper measures should be adopted to counteract the defect.

In the later months of pregnancy special attention should be paid to the cleanliness of the nipple. Daily washing to remove the scum of collected secretions, followed by the application of ordinary vaseline to prevent crust formation and to soften the nipple, is imperative. These points are stressed because they have great practical value. When the baby is put to the breast he instinctively opens his mouth widely and takes himself a mouthful. The suction which follows causes the nipple to advance towards the pharynx and come to rest between the base of the tongue and the soft palate. His gums and/or lips are thereby situated around the lacteal sinuses which are a short

distance behind the base of the nipple. By squeezing with his gums the lacteal sinuses are compressed and milk is literally forced out of the nipple. Note that the milk is not sucked out of the nipple, at least not forcibly, for it is impossible to exert much suction on an object situated between the base of the tongue and the soft palate. The nipple, therefore, is not subjected to much stress and trauma is correspondingly much less. If the above, which is the natural procedure, does not occur and the nipple lies between the gums, then the baby actually chews at the nipple and in a very short time a break in the surface occurs. This in turn leads to two conditions: (1) sore nipples, the pain of which is not infrequently excruciating, and (2) infection, with its dire consequences.

Our duty is obviously to prevent such a complication and this is best accomplished by following what has already been suggested for the antenatal period. Cleanliness of the nipples, the use of glass shields for any defect in the proper eversion of the nipples, and the use of an agent, such as vaseline, to soften them and the surrounding areola and skin, are measures that will save a great deal of worry in the puerperium. The elasticity of the nipple area is an important factor in allowing the nipple to advance to the soft palate region. Any condition, therefore, which hinders this will lead to trouble—for example, inelasticity, marked engorgement of the breast with edema of the skin, thereby preventing the baby from getting a proper grasp on the breast, and inversion of nipples.

During the lactating period a few complications may develop. The most common are sore nipples, engorgement, and infection, in that order of frequency. The first is the result of poor antenatal preparation and poor technique on the part of the mother. It is astonishing how few primiparas and even multiparas know how to nurse correctly. When the baby is put to the breast he receives a mouthful of milk which causes him to choke and gulp thereby frightening the

mother who pulls away from the baby and thereafter offers only the nipple. The baby then chews on the nipple and the ultimate result is soreness and abrasion. This abrasion is a source of infection which sometimes ensues. It is, therefore, imperative that all nurses should know these facts and enlighten the mother. Engorgement is the result of filling of the breasts with milk and incomplete emptying. They become full, heavy, overloaded, and unyielding, and the newborn does not get nourishment in the amount it needs. It is a discomforting condition but is not serious and can quite easily be treated. Infection is usually a sequel to "cracked nipples" and offers a minor problem.

Contraindications to breast feeding are few and seldom arise. Chronic infections, such as tuberculosis, acute infections of any kind, maternal debilitation, and perhaps cases of erythroblastosis are about the only ones. The last mentioned is not definite as yet but is being practised at this hospital because of the fear of transferring antibodies from the mother as indicated above. It should be pointed out that Cesarean section is no contraindication to breast feeding unless of course the mother is having a stormy post-operative recovery.

There are many other simple facts regarding the benefits of breast feeding but it will be evident from the above that nurses and doctors are the ones to encourage breast feeding because they know without doubt that:

1. There is no substitute for breast milk.
2. The mother benefits physically.
3. Fewer successfully breast-fed infants die than those fed with artificial milk.
4. "Anemia of infancy" is not uncommon and cow's milk contains less iron than does human milk.
5. The mother who has the milk and good nipples actually has less trouble than if she were using a formula.

Our efforts should not end with mere encouragement. We should demonstrate and insist on the prenatal care referred to above.

A Mother Breast Feeds her Baby

M. DORIS ANDERSON

Average reading time — 4 min. 6 sec.

DURING THE PAST YEAR we, of the Maternity Pavilion of the Vancouver General Hospital, have been changing our procedures for nursing mothers. Our aim is to ensure good lactation with maximum comfort and enjoyment. The results have been so gratifying that we hope that those interested in promoting breast feeding will consider the following suggestions.

The primipara, during the first day postpartum, nurses her baby on each breast for one minute, every three or four hours according to the needs of the baby. During the second day, she nurses her baby on each breast for two minutes, and so on, increasing one minute at each breast each day until a ten-minute period on each breast is reached. Some babies are quite satisfied after nursing for five or six minutes on each breast. With the multipara, the milk usually comes in more quickly so that the nursing time can be increased accordingly. Each mother is instructed to start the baby on the breast from which he finished the previous time. If he finished from the right breast at ten, he begins from the right breast at two and from the left at six. This prevents his always draining the same breast when he is more hungry and partially emptying the other one when he is more satisfied. It is of the utmost importance that the mother be in a comfortable position for nursing and that she be encouraged by all with whom she comes in contact.

With twins, for the first few days, each baby is put to the breast singly at each feeding, but when nursing satisfactorily they are put to the breast simultaneously. The mother sits up in bed with two pillows placed

diagonally across her lap and the babies are placed under her arms with heads forward and legs behind, leaving the mother's hands free to assist as necessary.



For the premature baby, the mother pumps her breast with a hand or an electric pump, according to the needs of the individual case, five times during the 24 hours. Later, when her breasts are sufficiently soft she is taught to express the milk manually. The massage incidental to this procedure aids in stimulating the milk supply. Recently a mother sent in 40 ounces of milk daily for her premature twins.

In cases of late lactation, when it is necessary to give a complementary formula, this should be kept to the minimum amount. Sometimes a little given after the evening feedings is sufficient.

The mother should be taught the symptoms of overfeeding, which are: crying after the feeding, colic, chewing the fists, diarrhea, and vomiting in spite of a good milk supply and a gain in weight. The treatment is to shorten the nursing time or to feed the baby on one breast only, at one feeding time.

The milk supply can be increased in a number of ways. The mother

Miss Anderson is nursery supervisor in the maternity department of the Vancouver General Hospital.

can drink more milk and water. She can take brewer's yeast. She can stimulate the breasts by emptying them completely by hand after the baby has nursed. This milk can be given to the baby as a complementary feeding after the next nursing. She can also stimulate the blood supply to the breasts by bathing them in hot and cold water alternately and finishing with a brisk but gentle massage.

Mothers are unanimous in their approval of this method because, apart from having very little trouble with nipples and being relieved of the feeling of lopsidedness, they are successfully breast feeding their babies and enjoying it.

The following is the record of Baby Wendy born in this department on October 15, weight 8 pounds 6 ounces, discharged on October 21, weight 8 pounds 5 ounces. The mother brought the baby to the follow-up clinic.

October 31: Weight 8 pounds 6 ounces. Symptoms of overfeeding present. Mother worrying. Weighed before and after one feeding—gain 8 ounces. The mother was instructed to nurse the baby

for five minutes only on each breast.

November 7: Weight 9 pounds—gain of 10 ounces during week. Symptoms of overfeeding still present. Buttocks red. The mother was instructed to give the baby one ounce of boiled water before the feedings.

November 14: Weight 9 pounds 14 ounces. Gain of 14 ounces during week. Water not given because the baby did not like it. Buttocks slightly red. Condition improving. The mother was instructed to apply paste to the buttocks, not to give water and not to worry.

November 28: Weight 11 pounds 4 ounces. Gain of 22 ounces during two weeks.

Condition excellent. Discharged from the follow-up clinic to attend the Child Health Centre.

The mother nursed Baby Wendy according to the routine noted above. She had an excellent supply of milk and overfed the baby but, with instruction and encouragement, the symptoms of overfeeding disappeared. At the age of about a month and a half the baby had gained nearly three pounds and was a very happy bright child.

Christmas

Santa is known by many names: Père Noël (Father Christmas) in *France*; Kris Kringle in *Germany* (from Christ Kindl or Christ Child); St. Nicholas in *Belgium*. In *Iceland* Santa comes in the form of a tiny elf and, though *Syrian* children have no Santa

Claus, they know of a tiny camel that accompanied the Wise Men. They leave bowls of grain and water outside their doors for this weary little traveller and, there as here, the good children find gifts on Christmas morning.

Educational Secretary Wanted

With a busy program of national importance before it, in the development of far-reaching educational projects, including the evaluation of schools of nursing in Canada, the Executive Committee of the C.N.A. is searching for a nurse with the right academic qualifications and sufficient experience to enable her to undertake this work with confidence. The minimum salary offered is \$4,000 per annum.

The Executive Committee is interested also in finding an *Assistant Secretary* for the staff at National Office. No specific requirements have been laid down but, all things being considered, preference will no doubt be

given to an applicant having superior academic qualifications, plus sufficient experience to enable her to undertake the detailed and varied secretarial work which this position requires. The minimum salary being offered for the Assistant Secretary is \$3,000 per annum.

The cooperation of the nurses of Canada in presenting applications for these two important positions is urged. Applications should be directed to **Miss Gertrude M. Hall, General Secretary, Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.**

"Hamlet" on the Maternity Ward

EPILOGUE

I could a tale unfold whose lightest word
Would harrow up thy soul.

Act I, Scene 5

Whose sore task
Does not divide the Sunday from the week.

Act I, Scene 1

7:30 A.M. REPORTS

In . . . all things will we show our duty.

Act I, Scene 2

CASE ROOM

There's a divinity that shapes our ends.

Act V, Scene 2

WARD WORK

Frailty, thy name is woman!

Act I, Scene 2

If there be any good thing to be done,
That may to thee do ease, and grace to me,
Speak to me.

Act I, Scene 1

ROUNDS BY THE CHIEF OF STAFF

I shall not look upon his like again.

Act I, Scene 2

It is a custom
More honour'd in the breach than the observance.

Act I, Scene 4

TIME OFF

Take thy fair hour . . . time be thine,
And thy best graces spend it at thy will!

Act I, Scene 2

VISITORS

A little more than kin, and less than kind.

Act I, Scene 2

4:00 P.M.

To pan, or not to pan,—that is the question:—
Whether 'twere better in the economy of time
To ask the visitor to pace the hall
While nature is attended to, or wait;—
To wait! perchance they'll ring; ay, there's the rub;
Just when the supper trays come down the hall
Or when a summons from the case room comes
Or when the lusty babe with squalling haste
Demands attention.

(with apologies) *Act III, Scene 1*

Though this be madness, yet there is method in't.

Act II, Scene 2

7:00 P.M. REPORTS

Sit down awhile,
And let us once again assail your ears,
That are so fortified against our story.

Act I, Scene 1

ANY FATHER TO HIS SON

Good-night, sweet prince.

Act V, Scene 2

ONE NURSE PUTTING 25 PATIENTS TO BED

This sweaty haste
Doth make the night joint-labourer with the day.

Act I, Scene 1

MIDNIGHT

For this relief much thanks.

Act I, Scene 1

Get thee to bed.

Act I, Scene 1

12:30-3:00 A.M.

The nights are wholesome.

Act I, Scene 1

For some must watch, while some must sleep.

Act III, Scene 2

And whatsoever else shall hap to-night,
Give it an understanding, but no tongue.

Act I, Scene 2

5:00 A.M. PANS

The time . . . out of joint.

Act I, Scene 5

The lady protests too much, methinks.

Act III, Scene 2

7:00 A.M. TEMPERATURES

My pulse, as yours, doth temperately keep time.

Act III, Scene 4

7:30 A.M.

O heavy burden!

Act III, Scene 1

Fain would I beguile the tedious day with sleep.

Act III, Scene 2

PROLOGUE

O heart, lose not thy nature; let not ever
The soul of Nero enter this firm bosom.

Act III, Scene 2

Assume a virtue, if you have it not.

Act III, Scene 4

And flights of angels sing thee to thy rest!

Act V, Scene 2

—ANONYMOUS

Lyle Creelman *Writes . . .*

Average reading time — 5 min. 12 sec.

ONE OF THE THINGS which makes living in Geneva so very interesting occurred recently. We attended a buffet supper given by Miss Marguerite Pohek, of the European Office of the United Nations Social Affairs Department, for 32 United Nations fellows. These students were from 16 countries and along with the extra guests 23 nationalities were represented. The fellows have very wide interests in the welfare field: industrial and child welfare, social insurance, rural welfare, delinquency, rehabilitation of the disabled, welfare of the blind and the deaf, etc. After a week of orientation in Geneva they will go to the United Kingdom for six months and will each have the opportunity of studying what is being done in their respective area of interest. The seven from Malaya will remain for two years, however, and will be studying at the London School of Economics.

A most interesting member of the group was Miss Kyniaki Kanelli from Greece, a totally blind girl travelling completely on her own. While in Geneva the Malayan group has accepted her as their special responsibility. Naturally her main interest is in blind children and she wants to find out what is being done in England so that she can return to help in the organization of their new school in Salonika. Her face brightens when she talks of her wish to learn more about what can be done for children who have never seen; she herself had sight until she was seven.

Five women from India among the group wore their colorful saris and the Malayan women were also in native costume. Those of us in ordinary western clothes were envious.

* * *

My friend, Helen Martikainen, and I have just returned from two weeks' leave in the south of France. We left our car at Hyères on the main-

land and, after a short boat trip, reached the delightful, undeveloped Ile de Porquerolles. It is one of a group of three islands, sometimes referred to as the Iles d'Or and, judging from the beautiful sunsets which we beheld in the evenings, we can easily understand why it was thus named.

This island is about five miles long and two to three miles wide. Parts of it are cultivated with vineyards and olive groves but mostly it is wild and rocky with pine trees and cliffs rising high above the sea. There are many beaches, the most popular of which is the Plage d'Argent which truly is a beach of silvery sand. Needless to say we spent many hours basking in the sunshine. We also explored the island from one end to the other and found the remains of several forts used in times past for protection against possible invaders. Between 1940 and 1945 the island was occupied by three foreign groups—first Italians, then Germans, and finally Americans. There were few English-speaking visitors apart from ourselves and we welcomed the opportunity to practise our halting French.

On our return we spent a few hours in the interesting city of Avignon. It is surrounded by a wall and inside is the famous Palais des Papes described by a French writer as "la plus belle et la plus forte maison du monde." This was the home of the Popes for the greater part of the fourteenth century.

Only part of the famous bridge of Avignon is standing. As we stood by the river to photograph the bridge a woman came down to the water to do her washing. This practice interested us in passing through the French villages in this part of the country. There seemed to be a communal laundry consisting of a large cement tank with a pump or tap at one end. It was divided, making sec-

tions for washing and for rinsing. We saw small ones and large ones and at the latter several women were busily soaping and rubbing their clothes. That makes washing time a really social gathering!

It was the season of the grape harvest. In the vineyards the luscious green and purple grapes were being picked and loaded into small horse- or donkey-drawn carts and taken to the winery to be made into the famous French wines.

We spent the night at the Hôtel Relais de l'Empereur in Montelimar. This was a favorite stopping-place for Napoleon. It has, of course, been renovated since his time but it still retains a delightful atmosphere of age and historical interest. The cuisine is excellent and I hardly need to say that both here and at Porquerolles we enjoyed immensely this feature of our French holiday.

* * *

To return to nursing—many of you will know Nancy Toy and Mary Harling. Nancy is from Brantford and has recently been working with the Child Health Association of Montreal. She is now in New Delhi, India, and is organizing the clinical teaching of pediatrics in the Irwin Hospital in cooperation with the New Delhi College of Nursing. In case you don't know already, the college gives a degree in nursing and this year their first four students graduated.

Mary Harling, from Montreal, was an instructor at the Montreal General Hospital. We interested her in going



MARY HARLING

to Penang, Malaya, where, along with three other WHO nurses, she is assisting in the development of the educational program of the school of nursing. When she was in Geneva we had a delightful week-end trip to Chamonix which nestles at the foot of Mont Blanc. Mary was introduced to her first *téléférique* ride and she seemed to enjoy it thoroughly. On our way back we passed through some delightful French and Swiss villages and in the photograph you will see her standing beside a fountain in one of them. You may know that in this part of the world every little hamlet has its fountain which, in the summer, is gay with flowers.

Cradle Song

O My deir hert, young Jesus sweit,
Prepare thy creddil in my spreit,
And I sall rock thee in my hert
And never mair from thee depart.

But I sall praise thee evermoir
With sangis sweit unto thy gloir;
The knees of my hert sall I bow,
And sing that richt *Balulaloe!*

—ANONYMOUS (16th Century)

Nursing Profiles

Muriel Archibald has assumed her duties as secretary-registrar and school of nursing adviser with the Association of Nurses of Prince Edward Island, a newly created position which followed the coming into effect of the new Nurses' Act in that province this year.

Miss Archibald has had excellent preparation for both the administrative aspects of her work and also the school of nursing activities. Born in Nova Scotia, Miss Archibald's preliminary education was received in Halifax and Charlottetown. She graduated from the Toronto General Hospital in 1930 and spent the following three years in private nursing in that city. A couple of years as matron of a private hospital in Trinidad preceded her enrolment in the course in teaching and administration in schools of nursing at the University of Toronto. Experience as an instructor followed at All Saints', Springhill, N.S., Jeffery Hale's in Quebec City, and Homoeopathic Hospital, Montreal. In 1948, she went to the position she has just vacated at the National Office of the Canadian Nurses' Association as the statistical worker. Miss Archibald's chief delights are her car and modelling in clay. She should have the opportunity of indulging in both these hobbies in Charlottetown.



MURIEL ARCHIBALD

Hazel Bernice Keeler has returned to her native province of Saskatchewan as director of the School of Nursing, University of Saskatchewan. This appointment is particularly appropriate in view of Miss Keeler's extensive experience in university work since

the program is to be considerably revamped to include specialized training in public health nursing or in teaching and supervision within the five-year course. Heretofore, Saskatchewan nurses have had to go outside their own province for the extra year's training.

Miss Keeler had already secured her B.A. from the University of Saskatchewan before she commenced her training at the Vancouver General Hospital in 1929. She received her certificate in teaching and supervision from the McGill School for Graduate Nurses in 1935 and five years later her M.A. from Teachers College. Her first position as a graduate nurse was as obstetrical supervisor at the Kootenay Lake General Hospital, Nelson, B.C. For four years she was science instructor in her own school of nursing, going from there to be clinical supervisor at the University Hospital, Edmonton. Following her work in New York, Miss Keeler was director of nurses at the Women's College Hospital in Toronto. In 1943 she undertook the organization of the School of Nursing Education, University of Manitoba. Since 1948 she has been on the faculty of the University of Buffalo. We shall watch with interest the development of these new courses under her gifted leadership.



Esquire Photo, Saskatoon

HAZEL B. KEELER

Janet Christina MacKay, R.R.C., is the new president of the Nursing Sisters' Association of Canada. Presently superintendent of nurses at the Lachine General Hospital, Que., Miss MacKay graduated from the Royal Victoria Hospital, Montreal, in 1923. She held head nurseships there until her enlistment with the R.C.A.M.C. in 1940. She served in England for two years as nursing sister in charge of the operating theatre with the Montreal Neurological Unit. Returning to Canada she was head of the operating room at the Rideau Military Hospital, Ottawa, for one year before becoming assistant matron at the Debert (N.S.) Military Hospital. For some time prior to her discharge from the services, Major MacKay was principal matron of the military district in New Brunswick. She was awarded the Royal Red Cross in 1944.

Miss MacKay is currently president of the Alumnae Association of the Royal Victoria Hospital. She is a member of the Soldiers Memorial Chapter of the I.O.D.E., Lachine. A busy person with many diversions, Miss MacKay brings outstanding qualities of leadership to her new role.



JANET C. MACKAY

Orma Jacklin Smith is pioneering a new position as adviser to schools of nursing in Alberta under the egis of the University of Alberta. Born in Saskatchewan, Miss Smith graduated in arts from the university there, receiving her professional training at the Vancouver General Hospital. Staff work for two years in the hospital at Burns Lake, B.C., was followed by her appointment as matron of the Enderby (B.C.) Hospital. Post-graduate work at the Toronto Psychiatric Hospital and a year as a head nurse in the

private pavilion of the Vancouver General Hospital preceded Miss Smith's enlistment with the South African Military Nursing Service. Soon after she received her discharge three years later, she enrolled in the course in administration in schools of nursing at the McGill School for Graduate Nurses. She later was appointed superintendent of nurses at the Galt Hospital, Lethbridge, Alta. More recently she was director of nurses and principal of the school of nursing at the Saint John General Hospital, N.B. Miss Smith will strengthen the present provincial nursing education program as she goes from school to school, as well as in her course of lectures at the university.



ORMA J. SMITH

Margaret MacKenzie, who for 30 years has been superintendent of the nursing services of the Department of Public Health, Nova Scotia, has retired. A native of Middle River, Victoria County, N.S., Miss MacKenzie received her professional training at the Victoria General Hospital, Halifax. She served overseas with the C.A.M.C. during World War I for four years. Following her return to Canada in 1919, she enrolled in the public health course at the University of Toronto School of Nursing, joining the department the following year. During her career the public health nursing service in Nova Scotia has grown from a few municipal nurses into an organization of 35 provincial nurses.

Miss MacKenzie was honored on the occasion of her retirement at a special ceremony held in the Office of the Minister of Health. At that time presentations were



Halifax Herald Ltd.

MARGARET MACKENZIE

made on behalf of the office and field staff. She retires with the good wishes of all her friends and associates. She plans to travel and renew old acquaintances before settling down in her home in Halifax.

Evelyn Kessler has undertaken an interesting piece of work at the Jewish General Hospital, Montreal. She is the new director of nurses and is completing plans for the opening of a school of nursing in conjunction with that hospital in the near future.

All Miss Kessler's previous nursing experience has been in the United States. A graduate of St. Elizabeth Hospital, Utica, N.Y., in 1934, she began as a staff nurse at the Willard Parker Hospital in New York City and worked up to the post of educational director nine years later. She secured her B.S. degree in nursing education in 1944. For the past three years Miss Kessler has been coordinator of instruction for Dillard University student nurses at Charity Hospital, New Orleans, La.



EVELYN KESSLER

Dame Ellen Musson, D.B.E., R.R.C., LL.D.

The Council of the Royal College of Nursing would place on record their appreciation of the work of Dame Ellen Musson, member of Council since 1919 and Honorary Treasurer during the years 1938-50, thereby expressing their gratitude for the wisdom and skill which she brought to bear upon their deliberations and for the great service which she rendered as Honorary Treasurer, especially during the difficult post-war years.

They would refer particularly to those special gifts through which, as a woman, a nurse, and an administrator, she brought great distinction to the profession she served. As a matron, councillor, and chairman of the General Nursing Council (1926-44), her professional knowledge, her learning, and legal attitude of mind made her an outstanding figure in her generation.

They are proud to feel that these qualities have been nationally recognized. In 1932 the University of Leeds conferred upon her the honorary degree of LL.D. and in 1939 His Majesty the King made her a Dame Commander of the Most Excellent Order of the British Empire. Internationally Dame Ellen Musson is recognized as one of the great influences in British nursing.

In paying tribute to Dame Ellen's qualities with affection and gratitude the Council would wish her much happiness and tranquillity in her years of retirement.

—*Minutes of the Council*

Old age, especially an honored old age, has so much authority, that this is of more value than all the pleasures of youth.—CICERO.

Public Health Nursing

Care of "His Majesty"

LOUISE P. BELL

Average reading time—7 min. 6 sec.

EVERY MOTHER knows two basic rules of baby care: scrupulous cleanliness and clocklike regularity. The new baby must be protected from all contamination as completely as possible until such time as he is old enough to have built up resistance to harmful bacteria. Therefore, he should be kept immaculately clean and sweet and so should every one of the tiny garments used on and around him. All should meet hygienic standards. "His Majesty" should, of course, also be on a regular feeding, bathing, and sleeping schedule, for these things help to make and keep him healthy.

He should be bathed daily, at least one hour after feeding. Most mothers find that morning is the logical time for this. Until the cord has separated and the umbilicus entirely healed, a sponge bath is the order of the day, with good soaping, rinsing, and drying the three steps. He should be kept covered as much as possible during these sponge baths so no drafts will strike his tiny body.

When the umbilicus is entirely healed, tub baths may be given. A bathinette is a great convenience or, as a substitute, set a small tub on a low stool or table. Half fill it with tepid water—warm but not hot to the elbow. Lay baby on a table over a folded towel and wash and dry his face with clear water—no soap. Then with well-lathered wash cloth of the very softest material you can find, start to wash baby's head carefully. If a scale appears, oil baby's scalp at night with sweet oil, then soap thoroughly, wash with warm water and dry gently next morning. If the condition does not clear up after two or three such treatments, speak to the doctor about it. Now undress baby

and, while he is still on the table, sponge his body all over with a soapy wash cloth. Lift baby from the table and place in the tub feet first.

Remember that a tiny baby can be easily frightened by rough handling, loud noises, and the feeling of being dropped. So hold him gently and talk to him softly as you lower him into the tub. Put your left arm and hand under his head and shoulders, grasping his left arm at the shoulder so as to hold him securely. With your right hand, grasp his feet and legs. Once he is in the tub the right hand can be freed to soap and rinse off his little body. Pay particular attention to the arm-pits, neck, and groin. Using both your hands, lift baby from the tub to the table and wrap him in a large soft turkish towel. Pat baby dry with the towel and smooth a little sweet oil in the soft, tender folds and creases or dust lightly with baby powder. The infant's nose and ears are best cleansed with a piece of soft absorbent cotton. The inside of the mouth should not be touched and baby's eyes should not be washed unless the doctor orders it.

CARE OF BABY'S CLOTHES

There are two things to consider in choosing baby's clothes: first, baby's comfort and protection; second, mother's time and energy in caring for baby's clothing. The more simple the clothing the better, so choose garments that are well designed, easy to put on and take off, and easy to wash for baby's clothes must be dainty, fresh, and clean at all times. Smooth absorbent diapers add to his comfort. Knitted lightweight cotton nightgowns are easy

to wash and require no ironing. Flannelette blankets are useful to wrap about baby and protect the wool blankets from becoming soiled quickly.

If you use a diaper laundry service, the diaper problem is solved. If you don't then be sure to have an adequate supply (three to four dozen) and get some of those paper diaper liners to tuck inside—they save lots of needless work. Diapers should be washed separately from other clothing, whether in a washing machine or by hand. As soon as they are taken off, they should be put to soak in a cold water-borax solution in a covered pail until they can be washed in hot soap-suds. Use a plunger or a small washboard if washing them by hand. Give diapers at least three thorough rinsings and hang them outdoors in the sunshine to dry. Once a week, boil them for about 15 minutes in clear water after rinsing. Occasionally, bleach the diapers if you dry them indoors. Use the bleach sparingly and follow the manufacturer's directions. Do not iron diapers. Just hang straight on the line and fold smoothly when dry.

Cottons need no special handling. Just wash them in warm soap-suds, rinse well, and dry outdoors. Iron only the prettiest, on-parade garments. Nightgowns, bands, and bibs need only be straightened as they are taken from the line. Baby's cotton quilted pads are washed in plenty of hot soap-suds, rinsed well, and allowed plenty of time for drying.

Baby's little woollies can be kept soft and in good shape if they are washed with care, using lukewarm suds, quick and gentle squeezing, several short washes in clean suds rather than one prolonged washing, and three gentle rinsings in lukewarm water. Press out the final rinse water carefully and remove further moisture by rolling the garment in a turkish towel, then shake out. If possible, dry sweaters, knitted caps, and wool-

len stockings on adjustable forms; or take the measurements of the woollies before washing and dry them on a flat surface, easing carefully to shape and size. Never dry baby's woollens in the sunlight or intense heat or cold. Bonnets may be dried over a padded bowl.

Follow the same washing procedure for silks and rayons as you use for woollies. Measuring is not necessary but when these are almost dry press on the wrong side with a moderate iron.

Babies' blankets should be washed often. The secret of washing blankets so that they retain their original softness and fluffiness lies in the use of plenty of tepid soap-suds, very careful handling, and proper drying. It is advisable to give blankets a three-minute run if washing them in a machine. Then rinse well in lukewarm water and run the blankets through a loose wringer. Hang evenly over the clothes-line to dry in a warm airy place. When partly dry, press out water that collects in the corners and pull the edges gently to shape. The same principles should be observed when washing blankets by hand—plenty of lukewarm suds, careful handling, and proper drying.

Since every baby dribbles fruit juice or cod liver oil on his clothes at one time or another, it is well to know the easiest way to take out these stains. "Immediately" is the word for the treatment. If they are allowed to stand, they become "set" and are either difficult or impossible to get rid of. For fruit juice stains on white cottons, try the old trick of pouring boiling water from a height through the stains, then wash in warm soap-suds as usual. Treat cod liver oil stains by laundering immediately. If a brown stain remains, you might try bleaching white cottons with peroxide, then rinse out bleach at once. Egg-stained cotton or linen should be soaked for a while in cold water than laundered.

By degrees the comforting light of what you may actually do and be in an imperfect world will shine close to you and all around you, more and more. It is this that will lead you, never to perfection, but always toward it.—JAMES LANE ALLEN

Puerperal Inversion of the Uterus

WALLARD S. HOLMES, M.D.

Average reading time — 4 min. 12 sec.

MRS. EADES, a primigravida 22 years old, was delivered precipitately in a neighboring nurses' home on her way to the Saskatoon City Hospital on November 3. Her calculated date was November 20.

A physician was summoned from a nearby village and arrived within an hour or so to find the placenta undelivered. The third stage of labor was accompanied by excessive bleeding, associated apparently with failure of the placenta to separate normally. The physician returned to the patient the next day and left orders with the nurse in charge for supportive treatment, also some sulfonamide for her fever.

On November 6, three days postpartum, the patient was brought by ambulance to the Saskatoon City Hospital. On arrival the hemoglobin was 22 and red blood cell count 1,190,000. The blood pressure was 100/56, temperature 102.6°, and pulse 120. She was not bleeding and nothing extraordinary was noted on inspection, apart from evidences of anemia. No vaginal examination was made. The fundus uteri could not be felt through the abdominal wall. The patient had difficulty urinating.

A transfusion of 500 cc. of citrated blood was given the evening of admission and this was repeated the next day. Penicillin, 20,000 units, was given intramuscularly every three hours and ferrous sulphate, gr. 5 t.i.d. p.c., was administered. The iron, food, and fluids were taken well by the patient, who felt well enough to ask about getting out of bed three days later.

Dr. Holmes is chief obstetrician at the Saskatoon City Hospital.

On November 10, four days after admission, when the temperature had fallen to 100° and the pulse was 100, the patient began to bleed quite profusely. She was prepared and taken to the operating room for curettage on the basis of a diagnosis of retained secundines. When examined under pentothal sodium anesthetic, the vagina was found to contain the everted uterus which completely filled the vagina but did not protrude from it. A plaque of placental tissue was adherent to the everted fundus. This tissue was removed and, after exploring the vagina, an attempt was made to replace the uterus manually. The patient became deeply shocked, however, so no further manipulation was done. Plasma, glucose, and blood were given intravenously and the patient was sent back to her ward. Three days later, after more blood had been given and with the patient much improved generally (Hb. 48, R.B.C. 2,660,000, W.B.C. 9,000.), she was taken back to the operating room and, under a low spinal anesthetic, the uterus was ultimately replaced by gentle persistent compression until its bulk was reduced sufficiently to permit gradual replacement, pressure being made upward at the cervical rim, so that the portion to evert last was replaced first. This manoeuvre was invented by Charles White in 1773. It took about one hour. The patient withstood the manipulation well. The uterine cavity was then packed tightly with gauze, which was removed the next day.

Blood was given during the operative procedure and afterwards. The temperature and pulse became normal about the 6th day after replacement of the uterus and the patient was

discharged November 22, 16 days after admission with a hb. of 57 and R.B.C. 3,230,000. She had had a total of approximately 3,300 cc. of citrated blood.

At the postnatal examination on December 17, no general nor pelvic abnormalities were noted. She brought her nine-pound baby along.

Puerperal inversion of the uterus is said to be the rarest obstetrical complication. While it occurs spontaneously, it probably results more often from forceful efforts to remove a placenta adherent to the fundus by pressure on the fundus uteri through

the abdominal wall and/or traction on the umbilical cord. Shock and hemorrhage always accompany this catastrophe, the former being proportionately more severe than the latter.

Where this complication of the third stage of labor is suspected, a vaginal examination is indicated, since an everted uterus may not be exteriorized and the diagnosis, therefore, delayed. Immediate replacement of the everted uterus by manual aid is the procedure of choice. The liberal use of blood and plasma cannot be over-emphasized.

In the Good Old Days

(*The Canadian Nurse*, December 1910)

"About a month ago the directors of the Winnipeg General Hospital, being anxious that the institution should attain to the fullest possible measure of usefulness, decided to establish a social service department."

* * *

"Provincial registration would do a great deal towards raising the educational standard of the nursing profession, as it would mean a standard would be set for all training schools to adopt, and no nurse would be able to call herself a registered nurse unless she had passed the examination set by the Board of Registration. It would also protect the public against the so-called experienced nurse who calls herself a trained or graduate nurse and charges the same fees as a nurse who has given three years of hard, earnest work and study for her diploma."

* * *

"When we state that fully one-third of the nurses in New York City today are Canadians we are making a very conservative estimate . . . Why do Canadian nurses come here and stay here? In Canada one hears

continually of the high salaries paid to professional people, especially nurses, in New York. Why is it that we hear so very little about the higher cost of registration, of laundry, of room rent, and of board? If the higher cost of living were as well known as salaries, it would make a difference."

* * *

"Miss Bella Crosby . . . has now been appointed Editor of *The Canadian Nurse* by the Editorial Board. She will enter on her new duties at once and the first number of Volume Seven (January, 1911) will be issued under her direction."

* * *

The graduates of the Stratford General Hospital Training School for Nurses have formed an alumnae association . . . Graduates from other schools residing in Stratford will be admitted as Associate Members and the third-year nurses-in-training will be admitted as Privileged Members, having the privilege of attending regular meetings and taking part in discussions, but may not vote or hold office.

If you're not serving a holiday punch, you may prefer to fill your bowl with figs and raisins and walnuts and sweets—the traditional "end" of any Christmas dinner. In so doing, you are following, in part, an

old Greek custom called "The Luck of Christmas," for Greek youngsters go out on Christmas morning to collect the same figs and raisins and walnuts and sweets that crown our holiday tables.

Aux Infirmières Canadiennes-Françaises

Aperçu sur le Service Social à l'Assistance Maternelle

FERNANDE VERRET

Average reading time — 15 min. 36 sec.

AU SERVICE d'hygiène et médical de l'Assistance Maternelle de Québec, comme dans bien d'autres services, la période récente a été marquée par un vaste effort pour l'application des techniques du service social. Les difficultés et les problèmes rencontrés chez les patientes ont créé, en effet, le besoin, la nécessité d'appliquer ces théories.

Avant d'entrer dans le vif du sujet, je rappellerai brièvement le but de cet organisme qui est d'aider à diminuer la mortalité maternelle et infantile chez-nous, en procurant gratuitement aux futures mères peu fortunées les consultations prénatales, les services et soins du médecin et de l'infirmière lors de l'accouchement à domicile et durant les suites de couches. Pour celles qui doivent être hospitalisées, un lit est retenu pour elles à l'hôpital. En plus, des médicaments prescrits, le service distribue le lait, la layette, et la literie.

En 1948, pour répondre à une demande faite par l'université, une clinique d'enseignement obstétrical a été organisée, c'est-à-dire que les finissants en médecine assistent aux cliniques de consultations prénatales et ils accompagnent le médecin aux accouchements.

Si nous reconnaissons qu'il existe des maux d'ordre physique ou psychique, il faut admettre qu'il existe aussi des maux d'ordre économique, social, familial et émotionnel. Nous avons tous journellement de multiples problèmes

à résoudre, malgré la vie relativement normale que nous menons. Que dire alors des miséreux, des inadaptés, des mécontents, et des révoltés? Si nous voulons atteindre notre but—favoriser une maternité plus heureuse, contribuer au bien-être de la mère et de son enfant—nous ne devons pas ignorer ces aspects dans une clinique prénatale. En un mot, tout programme de santé qui a pour but de promouvoir la santé de la mère et de celle de son enfant ne doit pas négliger l'importance des facteurs économiques, sociaux, familiaux, et émotionnels en fonction de leurs vies et de leur bien-être présent et futur. Si nous reconnaissons ces facteurs dont l'influence se fait également sentir sur la vie de l'enfant et si nous essayons de satisfaire aux besoins de la future mère, nous contribuons hautement non seulement au bien-être de celle-ci, mais nous assurons aussi au nouveau-né les avantages d'une bonne santé à la naissance et les possibilités quasi assurées que lorsqu'il atteindra sa maturité on pourra le classer parmi les adultes bien adaptés.

Nul n'ignore, en effet, que les impressions créées chez un enfant durant les six premières années de son existence peuvent avoir une influence capitale dont il ressentira les effets le reste de sa vie.

Voilà pourquoi le médecin, l'infirmière, et l'assistante sociale constituent une équipe qui cherche à réaliser de meilleures conditions sociales et ce travail d'équipe est essentiel pour atteindre l'objectif fixé.

Toutefois, ce service social dans une

Mlle Verret est directrice du Placement Familial, Cité de Québec.

clinique prénatale doit prendre une physionomie particulière en fonction des difficultés de la femme enceinte, des cadres du service et du milieu.

Le service social, en plus de la science et des techniques que ce travail exige, c'est avant tout quelque chose de profondément humain qu'on peut appeler l'amour raisonné de son prochain auquel il faut venir en aide en l'acceptant tel qu'il est, tel qu'on le trouve, et non tel que nous voudrions qu'il soit. L'essence même du service social c'est d'avoir, de posséder à un haut degré le sens social. Ce sens social se caractérise surtout par une tournure d'esprit particulière, compréhensive, une attitude sympathique mais constructive envers les personnes avec lesquelles nous traitons.

Si vous le voulez bien, nous jetterons ensemble un coup d'oeil sur le travail accompli et susceptible d'être accompli en tenant compte de tous les facteurs déjà mentionnés. Or, dans une clinique comme la nôtre, l'on attache une grande importance à la première entrevue de la patiente soit avec l'infirmière, soit avec l'infirmière assistante-sociale. Qui nierait l'influence exercée sur nous par une première impression? La personne même la plus objective n'en est pas exempte; les psychologues l'avouent, l'expérience le prouve, et tous le proclament. Ce sont toutes des futures mères qui se présentent au service; cependant, combien différentes elles sont! Elles confirment sans contredit la loi naturelle d'individualisation. Quelques-unes d'entre elles sont ignorantes, naïves, ou imbuës de préjugés; d'autres nerveuses, d'autres phlegmatiques, d'autres bien avariés par une misère physiologique ou morale qui se trahit par des caractéristiques non équivoques. D'autres, par contre, s'attendent à tout, car elles ont déjà tout subi; d'autres encore sont révoltées et insatisfaites. Il y a aussi un certain nombre de patientes qui semblent équilibrées et peu compliquées. La plupart cependant ont ceci en commun: "la crainte." A quoi doivent-elles s'attendre de nos services? Réaction incontestablement généralisée chez un

grand nombre d'humains. Ce sentiment est plus accentué ici, à cause du préjugé d'une fausse impression et croyant qu'elles auront des services moindres que ceux donnés chez le médecin privé, en raison du fait que nos services sont gratuits.

De la première entrevue dépend l'acceptation par les patientes des conseils, soins, et services qu'on lui offre. Que vient chercher cette personne au service, qu'attend-elle de nous?—une aide financière, de la sympathie, une compréhension amicale, des directives? Tout cela et même davantage. En somme, il faut tenter de refaire une partie de son éducation, lui démontrer l'importance et la nécessité des consultations périodiques avec le médecin; lui indiquer la ligne de conduite à suivre en regard du régime de vie, de l'alimentation, etc. Il est de toute évidence que de cette première rencontre dépend le succès du but à atteindre et auquel seule la discipline que s'imposera la future mère peut assurer. Il faut que la patiente se rende compte de la nécessité des examens préconisés pour elle et pour son enfant, qu'elle sache le pourquoi des soins donnés, du régime, et de l'alimentation imposée par sa condition. La patiente est dispensée, lors de son inscription, d'un questionnaire fastidieux. Celui-ci, me direz-vous, est nécessaire. C'est exact, mais il doit se faire sous la forme d'une conversation amicale et au cours de laquelle on doit noter les faits essentiels quant à l'histoire médicale et sociale.

On évite ainsi de blesser la patiente, en l'obligeant dès cette première entrevue, à étaler soit sa pauvreté, son désarroi moral, ou sa misère. L'expérience a démontré que cette méthode donne des résultats pratiques qui permettent d'obtenir tous les renseignements indispensables. N'est-il pas vrai qu'on évite un ami aux questions indiscretes et que souvent on se confie plus facilement à ceux qui semblent moins anxieux de connaître nos problèmes personnels? A nous de constater et de vérifier par la suite si nos observations sont précises et bien fondées.

AU POINT DE VUE ECONOMIQUE

Tous admettent qu'il y a des familles moins bien partagées les unes que les autres. C'est précisément dans ce milieu que nous évoluons. Or, il faut intervenir auprès des services sociaux déjà existants afin qu'on procure à ces personnes la nourriture, le chauffage, les vêtements, et même faire les frais du loyer dans certains cas. Dans d'autres cas, il faut aussi intervenir afin d'obtenir des pensions et il faut même les administrer lorsque le chef de famille s'avère incapable de le faire. De plus, lorsque des patientes doivent être hospitalisées et pour lesquelles il est difficile de demander les secours de l'assistance publique, soit que leur cas ne se conforme pas aux exigences de la loi de l'assistance publique, soit en raison d'une naissance qui crée l'impression d'être prématurée ou pour toute autre complication. Ces patientes peuvent donc grâce à notre organisme bénéficier de conditions spéciales pour l'hospitalisation.

AU POINT DE VUE EMOTIONNEL

Presque toutes les futures mères, et particulièrement celles que nous traitons, sentent le besoin et l'opportunité de s'extérioriser. Cette réaction émotive se traduit généralement par le désir d'exprimer ses inquiétudes, d'être écoutée, d'être comprise, d'être orientée. Si cette réaction est refoulée, elle peut déclencher de l'anxiété dont les effets seront aussi funestes pour la santé de la mère que pour celle de l'enfant.

De plus, la future mère doit savoir qu'il ne suffit pas simplement de donner à manger, de garder au chaud le petit pour répondre à ses besoins. Elle doit lui procurer, dès sa plus tendre enfance, l'affection dont il a besoin. Cette affection peut déterminer et influencer dans une large mesure l'adaptation de l'enfant aux différentes périodes de sa vie. L'attitude des parents envers la venue de l'enfant peut avoir également une influence heureuse ou malheureuse sur toute la vie de ce dernier. Bref, un bon nombre de futures mères ne sont pas prêtes émotionnellement à remplir

le rôle de mère. Elles ont fréquemment le sentiment que les responsabilités nouvelles seront plus grandes que les joies que leur procurera le nouveau-venu.

CERTAINS FACTEURS SOCIAUX

Le milieu, l'attitude erronée de parents, d'amis, l'accumulation de préjugés et de superstitions envers les soins prénataux entravent, influencent, et retiennent même quelquefois la future mère à l'écart des soins préconisés.

Nous devons donc assurer dans nos cliniques un service d'une courtoisie attachante, devenir la confidente des patientes, leur éviter les longues heures d'attente, et surtout ne jamais brusquer ces personnes qui sont généralement plus susceptibles que leurs soeurs plus fortunées que nous rencontrons chez le médecin privé.

Pour toutes ces raisons, il faut donc s'efforcer de remédier à certaines lacunes; écouter celles qui éprouvent un véritable soulagement à raconter leurs déboires, leurs scrupules, et qui espèrent recevoir une directive, une opinion qui les aideront à sortir du dilemme où les a enfermés leur inexpérience de la vie ou très souvent une éducation faussée. Il faut tenter de créer chez ces personnes une certaine indépendance rationnelle qui les aidera à réaliser l'épanouissement de leur personnalité et à atteindre leur maturité d'esprit.

Ce travail préliminaire se complète souvent d'un travail d'interprétation de normes et de principes fondamentaux oubliés et méconnus tels que: la nécessité du travail, la stabilité au travail, la solidarité qui doit exister au sein de la famille, etc. En un mot, c'est un travail de rappel aux lois naturelles auxquelles nous ne pouvons nous soustraire sans causer le désordre et le malheur. Il faut aussi essayer d'apporter une solution aux problèmes de personnalité, de mésentente conjugale, due maintes fois à l'ingérence d'une belle-mère, à la jalousie, ou à la crainte de maternités trop souvent répétées.

Dans un grand nombre de cas de personnes désespérées, il suffit d'ap-

porter une thérapie de support, de compréhension, de rectification d'attitudes, et de jugement.

Bref, la science, la compétence, la

compréhension, la patience, et la bonté doivent être les instruments de toutes celles qui aspirent à jouer un rôle dans les services sociaux.

Wrapping Your Christmas Parcels

PACKAGES—gay and varied, colorfully wrapped and ribbon-tied—are, for many of us, the visible symbol of the gay and festive spirit that is in the air, everywhere, at Yuletide. Your packages can really be “something to talk about” this year. You needn't be limited by the traditional red, and green combination—good as that always is—for many new papers, new ribbons, and new colors are now available.

A new fluorescent ribbon, to be had this year in bright glowing tones, has a special finish which gives a luminous sheen. When used with the new dark papers, or those with a suede-like surface, you will achieve a package that is very 1950 in appearance. Then, too, there are the latest versions of the glittery tinsels and metallic ribbons, the shiny satins, and timely printed ones. These, together with the rich foil papers, lovely plain-colored ones, and others telling the Christmas story in pictures, all

are designed to help you make your packages extra special.

Choose ribbons that will blend or contrast with your paper. For instance, a moss-green ribbon on a gold-papered box becomes more exciting by the addition of a touch of flaming tangerine. Cerise and white bows on pale blue paper; a lemon-yellow ribbon tied around a dark green package, with scarlet for accent; or lime and brown ribbons on paper of a coppery tone indicate some of the more unusual ways in which to use color.

To make lovely packages, you need not tie yourself into knots—either literally or figuratively. The ability to wrap packages beautifully is not the prerogative of any one small group—it is a skill that can be mastered by all of us—and here's how . . .

Wrap it—and tie it: Clear an adequate working space—flat, firm, and with plenty of elbow-room. Assemble all your equipment: scissors, seals, glue, ribbons, papers, boxes, etc. Wrap your gift in fresh tissue and place it in a box of proper size. If the paper has a pattern, be sure you so place the box that the design will be well spaced on the top. Fold paper over, pull smooth and taut, fold ends neatly and fasten with scotch tape or decorative seals. If box is large, tape two sheets of paper together and proceed as you would with a single sheet. The seams may be concealed with ribbon. Two different colors, or a printed paper combined with a plain one, will produce a novelty effect.

And make a bow: No matter how you
(continued on page 993)



Ribbon Guild, Inc., New York
You can do it too!

Trends in Nursing

Average reading time - 7 min., 36 sec.

The Canadian Way

THE JOINT PLANNING COMMISSION on Adult Education tried out something new in discussion leadership at the spring conference this year. Three observers of the Canadian scene were asked to speak, at the opening of the session, on the general question of the big ideas about which all member bodies should be concerned. The main message of the three speakers was that member organizations should be more concerned with understanding Canada's position in world affairs and the working of Canadian democracy. They intimated that many Canadian education agencies went about their business almost unaware of the fact that our relationships with other countries are of the utmost daily importance to each of us. They suggested that we seem inclined to accept the existence of Canadian democracy in a mildly stupid sort of way, failing to understand just how and why it works and not realizing that circumstances could snatch it away from us. The Joint Planning Commission was convinced that the two big ideas to be recommended for study in the coming year are: (1) the Canadian economy in relation to world affairs; (2) the problems of Canadian democracy.

—*Food for Thought*, Oct. 1950.

Fact Finding

A sickness survey being conducted by the Saskatchewan Public Health Department, in cooperation with Ottawa authorities, started September 1, Malcolm G. Taylor, director of the department's Research and Statistics Branch, has announced. The survey will be national in scope and has been initiated by the Department of National Health and Welfare and the Dominion Bureau of Statistics.

In each province, including Sas-

katchewan, a number of urban communities and rural areas have been selected as samples, representative of the entire population, Dr. Taylor said. The survey will take in 21 farming areas.

In Saskatchewan, enumerators are under the supervision of Miss K. Stephen, Regina, and the information-gathering will be conducted for one year, with monthly visits to households. Information to be sought will include environmental factors in sickness, such as housing, water supply, food preserving, and heating; individual illness; and money actually spent on health services, including medical care, dental care, hospitalization, drugs and appliances. All information obtained will be treated confidentially and the analyses will be done by the Dominion Bureau of Statistics at Ottawa.

The survey is intended to provide the federal and provincial health authorities with valuable information as a basis for extension of preventive services and health insurance planning.

—*Saskatchewan News*, Sept. 1950.

International Standards

A major achievement in international cooperation received suitable recognition as the Third World Health Assembly adopted unanimously for world use a set of 39 international standards for biological substances, among them standards for vitamins, vaccines, sera, antibiotics, and other products. Standardization of these substances for international use started under the League of Nations Health Organization and is being continued by the World Health Organization.

—*WHO Newsletter*, June-July, 1950.

International Pharmacopeia

The English version of the first International Pharmacopeia, contain-

ing descriptions of some 200 drugs in general use, is now completed. Prepared by the WHO Expert Committee on the Unification of Pharmacopeias, it will probably be published in a French and a Spanish edition as well before the end of 1950.

—*WHO Newsletter*, June-July, 1950.

Register of Refugee Nurses

Many nurses have been found among the masses of people who fled their countries during and after the war and who eventually came under the care of United Nations through its specialized agencies.

The International Refugee Organization assembled a Professional Nurses Screening Board to interview these persons and to establish the professional status of those who claimed to be qualified nurses. Members of this board were nurse representatives of their countries who had been leaders in their profession.

The board compiled a register of professional nurses which has been particularly valuable to individual nurses, nurse registration boards, and prospective employers. Many nurses who might have been lost to the profession have been re-established in nursing work after their professional status was determined. The nursing profession, also, is protected.

In order that this service may be continued, an agreement has been reached to transfer this Displaced Persons Professional Register to the International Council of Nurses. Alice Sher, assistant executive secretary, who is president of the Nurses Screening Board, will be responsible for this program which will include: (a) providing professional advice to nurses in past or present refugee status; (b) establishing professional status of the individual nurses; (c) amending the nurses' register.

—*American Journal of Nursing*, Aug. 1950, p. 478.

International Classifications

The French and Spanish editions of the "WHO Manual of the Interna-

tional Statistical Classification of Diseases, Injuries and Causes of Death" have recently been published and are now on sale at all booksellers carrying WHO publications as well as at the Palais des Nations, Geneva. The Manual, which first appeared last year in English, is designed to ensure as far as possible uniformity and comparability of health statistics. It provides for the first time a single method for reporting both diseases and causes of death and is, therefore, of invaluable assistance to hospitals, clinics, social security administrations and insurance companies.

Educational Workshops

Many nurses met at Vina del Mar, Chile, under the auspices of PASB and the Government of Chile for an educational workshop dealing with problems in administration, supervision and teaching methods in nursing education and public health nursing.

The purpose of the workshop was to help participants find solutions to problems arising in their everyday work through study, discussions, and interchange of ideas. Meetings of small groups permitted participants to uncover problems which they wished to study more fully. Individual consultation was also given on special problems by the members of the teaching staff, representing all aspects of nursing education and public health nursing.

—*WHO Newsletter*, Aug.-Sept. 1950.

Appraisal of Nursing Care Needed

We have found . . . that traditions and outmoded procedures play an important part in present-day nursing care, consuming valuable nursing time. We have estimated that roughly 128,000 nursing hours, or the time of 63 full-time nurses, are spent each year in Indiana hospitals providing care in the obstetrical service that is unnecessary, while many essential jobs are left undone. This indicates a need for the evaluation of present

nursing care, the adjustment of policies and procedures, and the development of a plan to meet present-day patient and hospital needs.—L. E. BURNEY, M.D.

—*A.J.N.*, July, 1950, p. 409.

Professional Accreditation

Marion Sheahan, director of programs for the National Committee for the Improvement of Nursing Services, spoke of the areas in which this committee will work. Major emphasis for the immediate future will be placed on professional accreditation of all nursing schools eligible for such accreditation. Another step is toward the improvement of nursing services through improvement of nursing service administration. Basic to these, she said, is an information program for the development of professional relationships which will bring about

better understanding of the program by nurses, other professional and allied groups, and government agencies.

—*A.J.N.*, Sept. 1950, p. 577.

Clinical Instruction

A challenging article on this topic by Joan H. Bourne appears in *Nursing Times*, July 22, 1950 (p. 750). Miss Bourne explores her subject critically and from many angles. While citing experiences gained in Canada and particularly at the School of Nursing, University of Toronto, she emphasizes the need to adapt the program to the particular situation. A short article follows on page 763 entitled "Clinical Teaching in a Norwegian Hospital" and is by Aagot Lindstrom, Ulleval Hospital, Oslo. Both of these articles express a point of view that might well repay consideration.

Orientation et Tendances en Nursing

ET AU CANADA

Le Comité d'Organisation pour l'Éducation des Adultes a inauguré un nouveau genre de discussion. Trois observateurs de la vie canadienne furent invités à adresser la parole à la séance d'ouverture sur un sujet de leur choix, lequel, néanmoins, devait intéresser tous les groupes faisant partie de l'association pour l'éducation des adultes. Les trois conférenciers furent unanimes à conseiller aux groupes intéressés à étudier davantage la position du Canada dans les affaires du monde et la démocratie canadienne.

Ces conférenciers insinuèrent que des associations s'occupant de l'éducation des adultes faisaient leur travail presque sans se rendre compte que nos rapports avec les autres pays ont une importance qui se fait sentir tous les jours dans la vie de chacun. Nous faisons la bêtise, dirent-ils, d'accepter la démocratie canadienne comme une chose telle quelle, sans savoir au juste comment elle fonctionne et sans réaliser que dans certaines circonstances elle pourrait nous être enlevée.

Le programme de l'année prochaine com-

prendra ces deux idées importantes: (1) l'économie canadienne en relation des affaires internationales; (2) le problème de la démocratie canadienne.—*Food for Thought*, oct. 1950.

DES FAITS

C'est sur les maladies que portera l'enquête qui sera faite par le Ministère de la Santé Publique de la Saskatchewan, en coopération des autorités fédérales. L'enquête sera sur une base nationale et a été commencée par le Département National de la Recherche et le Bureau Fédéral de la Statistique. Dans chaque province, la Saskatchewan comprise, un nombre de centres urbains et de centres ruraux ont été choisis comme centre d'échantillonnage de la population totale de la province. L'enquête portera sur 21 centres agricoles. L'observation durera un an et comprendra une visite mensuelle à chaque famille. On cherchera des informations sur le milieu, sur les facteurs pouvant avoir une influence sur la maladie—tel que, le logement, l'approvisionnement de l'eau, la conservation des aliments, le mode de chauffage; les maladies

individuelles; argents actuellement dépensés dans les services de santé, comprenant les soins en maladie, le soin des dents, l'hospitalisation, médicaments, etc. Toutes les informations obtenues seront confidentielles et l'analyse en sera faite par le Bureau Fédéral de la Statistique à Ottawa.

Cette enquête a pour but de fournir aux gouvernements fédéral et provinciaux des renseignements précieux, lesquels serviront à l'extension des services préventifs de santé et dans la préparation des plans d'assurance.—*Saskatchewan News*, sept. 1950.

ENFIN! DES NORMES INTERNATIONALES

Des normes internationales pour les produits biologiques, vitamines, vaccins, sérums, etc., ont été adoptées à la Troisième Assemblée de Santé Mondiale. La standardisation de ces produits, pour en faciliter l'usage à travers le monde, a été commencée par le Service de Santé des Nations Unies et achevée par l'Organisation Mondiale de Santé.

UNE PHARMACOPÉE INTERNATIONALE

La première pharmacopée internationale, version anglaise, vient d'être complétée. Elle contient plus de 200 médicaments d'usage courant. Préparée par un comité d'experts, cette unification de diverses pharmacopées sera probablement publiée en français et en espagnol d'ici la fin de l'année.—*WHO Newsletter*, juin-juillet, 1950.

CLASSIFICATION DES MALADIES

Un autre travail important réalisé par O.M.S. a été la publication en français et en espagnol d'un manuel de classification internationale des maladies, des accidents, et des causes de décès. Ce manuel est en vente dans toutes les librairies qui vendent les publications de O.M.S.

Ce manuel, publié l'an dernier en anglais, a pour but d'établir une uniformité qui permettra d'établir des comparaisons dans les statistiques de santé. Cette publication est appelée à rendre de grands services aux hôpitaux, aux administrations d'assurances sociales, comme aux compagnies d'assurances en général.

FOYER D'ÉTUDE AU CHILI

Un groupe d'infirmières du Chili ont tenu des foyers d'étude, sous les auspices du gouvernement du Chili et de la P.A.S.B. Durant ces journées d'étude, des problèmes concernant l'administration, la surveillance et les

méthodes d'enseignement dans l'éducation des infirmières et en hygiène publique ont été étudiés. En plus, des discussions et des échanges d'idées entre petits groupes et des consultations individuelles furent données par les consultants sur tous les aspects de l'éducation des étudiantes infirmières et sur l'hygiène publique.—*WHO Newsletter*, août-sept. 1950.

LA VALEUR DES SOINS AUX MALADES

La tradition joue un grand rôle dans les soins donnés aux malades; certaines techniques aussi démodées qu'inutiles sont encore employées. Dans des hôpitaux d'Indiana, l'on a estimé que 128,000 heures de soins, donnés dans un service d'obstétrique par 63 infirmières, sont d'une part inutiles et d'autre part des soins nécessaires ne sont pas donnés. Cela demande la nécessité d'analyser et d'évaluer les soins donnés par les infirmières et d'adopter des techniques et une ligne de conduite plus en rapport avec les besoins actuels.—*A.J.N.*, juillet, 1950, p. 409.

ACCREDITATION DES ÉCOLES D'INFIRMIÈRES AUX ÉTATS-UNIS

Le comité, formé pour l'amélioration des services aux malades, a mis en tête de son programme l'accréditation des écoles d'infirmières, nous communiquait Mlle Marion Sheahan, convocatrice. L'amélioration de l'administration de ces services est aussi au programme. D'une égale importance est un programme d'information ayant pour but de faire mieux comprendre aux infirmières, aux autres professions connexes, et aux services des gouvernements le travail que se propose de faire ce comité.—*A.J.N.* sept. 1950.

L'ENSEIGNEMENT CLINIQUE

Un article, faisant réfléchir, a été publié sur ce sujet dans le *Nursing Times* (juillet 22, 1950, p. 750). L'auteur, Mlle J. H. Bourne, parle de son expérience au Canada et appuie sur la nécessité d'adapter le programme à une situation bien déterminée. Dans le même numéro, à la page 763, on peut lire un court article intitulé "l'Enseignement Clinique dans un Hôpital de Norvège." Les infirmières qui feront une lecture attentive de ces deux articles en retireront de grands bénéfices.

UN REGISTRE POUR LES INFIRMIÈRES VENANT DES PAYS OCCUPÉS.

Des foules de gens ont dû abandonner leur pays après la guerre et se sont trouvées sous

la protection des Nations Unies. L'Organisation Internationale des Réfugiés a formé un bureau d'examen pour infirmières professionnelles. Ce bureau a été chargé d'interviewer les personnes qui se disaient infirmières professionnelles et d'établir leurs qualifications. Ce bureau était composé d'infirmières des plus compétentes, qui représentaient leur pays respectif.

Le bureau a ouvert un registre d'infirmières professionnelles qui a rendu de grands services—individuellement aux infirmières, aux futurs employés, et aux associations d'infir-

mières. Sans ce registre, bien des infirmières n'auraient pu établir leurs qualifications et leurs services auraient été perdus pour la société.

Le registre sera transporté au bureau du Conseil International des Infirmières. Le programme du service que le bureau se propose de donner est le suivant: (a) conseils professionnels aux infirmières des pays déplacés; (b) établir les qualifications individuelles des infirmières; (c) améliorer les registres d'infirmières.—*American Journal of Nursing*, août, 1950, p. 478.

Wrapping Your Christmas Parcels

(concluded from page 988)

choose to tie the ribbon around the box (crossed through the middle for a square box, crossed at either or both ends for an oblong one, etc.), the *bow* is always made separately and attached to the box later.

To make a big, full bow, use ribbon 2" to 3" wide. Pinch gathers in ribbon about 3" from one end and hold between thumb and forefinger of left hand. With right hand, make a loop about 2" long and pinch in gathers. Continue looping ribbon back and forth, always holding finished loops in left hand, until you have made enough to give the desired fullness. (The narrower the ribbon, the more loops that will be needed.) Tie tightly through centre with wire or ribbon. Fluff out loops into a round puff and attach bow to package. About 3 yards of ribbon is required for a nice full bow.

For a tailored, two-toned trimming: Use two contrasting ribbons (print and plain or different colors), each about 1" wide. Place wrong sides of ribbons together and lay flat on table. Make a series of flat loops working back and forth, keeping each loop directly over the one below and a little shorter. Keep centre flat—do not pinch into gathers. Secure to box centre with scotch tape and pin flowers, berries, or an ornament over the centre.

Adding the gingerbread: Little angels, snowmen, animals, etc., may be placed

on the package; sprigs of holly or spruce or other greens tucked in with the bow add a seasonal note. Try tying a soft knot near the end of 4 or 5 extra lengths of ribbon. Attach these to the box under the bow so they will fall loosely across package.

Give your packages a fairy touch by the use of "flitter"—a glittering, sand-like material. It comes in red, green, blue, gold, or silver at art or gift shops. It may be used on the ribbons or directly on the package. The parts to be decorated are lightly touched with mucilage, flitter sprinkled on generously, and the excess shaken off. Another way of getting glitter on your packages is to attach small Christmas balls to the ends of the tying ribbons. Remove the cotter pin from the ball, push one end of pin through the edge of the ribbon, and then replace both ends in the ball.

For packages with sound effects, attach small bells to loops of ribbon and string, clothes-line fashion, across the box.

Did you know that metallic and tinsel ribbons will curl? Simply draw the ribbon over the blunt edge of a knife. If you cut 10"-lengths, tie them together in the centre, and curl each end, you will have a fluffy, "curlicue" rosette.

Are round parcels your problem? One answer is to wrap them with aluminum foil—it's very crushable and molds easily to shape. You can tie a big red bow at

one end or dress it up with a ribbon skirt. To make this "skirt," glue lengths of $\frac{1}{2}$ "-wide ribbon to a matching band of wider ribbon. Fasten the band around one end so that strips hang to the bottom edge. The more strips, the fuller the skirt. You can attach small bells to some of the strips, to tinkle jovially each time the parcel is lifted. Another way is to roll it in paper. Have the paper longer than the roll and slash the ends to form a fringe. Tie with ribbon bows, and lo! it has turned into a giant party "snapper." If you use plain white paper, wind red ribbon spirally around the cylinder and top with a red Christmas ball—you'll end up with a miniature barber pole.

For the male of the species, omit the frou-frou. If you use bows, make them flat and tailored. Choose masculine colors in both paper and ribbon—browns, dark greens, greys, etc. The package may

be decorated with pictures typical of masculine interests, such as sport scenes; or it may be trimmed with gadgets indicative of a particular hobby—i.e., colorful fishing flies, a toy gun, miniature camera, deck of cards, or even bright packages of seeds. For the "strictly business" man, wrap your offering in the financial page of the local paper, tie with gold ribbon, and decorate with play money—bills and coins.

Packages that show care and personal interest will enhance whatever you may give; for any gift means only as much as the thought behind it. Packages can have personality, too—they can be original, and ingenious, and beautiful . . . a compliment to the receiver and a source of pride to you, the giver.

—*Ribbon Guild News*

Treatment for Shock

A group of leading American surgeons has advised the U.S. Public Health Service that salt water taken by mouth, in a vast majority of cases, is as effective as blood plasma in the emergency treatment of shock from serious burns and other injuries.

In general terms, the treatment calls for approximately one level teaspoonful of table salt and one-half teaspoonful of baking soda for each quart of water. A number of quarts are required each day. The only limitation on the amount taken is the ability of the patient to consume the saline solution. Since great thirst accompanies serious burn injury, it has been found that patients will voluntarily swallow a sufficient amount of the solution, which is quite palatable. No other drinking fluid is permitted in the first few days following injury.

In releasing the recommendation, Surgeon General Leonard A. Scheele said: "The findings are of particular importance in a period of war emergency, since it is estimated that in the event of atomic bombing about 60 per cent of the surviving bombed population might suffer from burns. This figure, moreover, does not account for injuries other

than burns in which shock also might be present.

"Salt water offers an easy, practical method for the treatment of shock which follows serious burns and other injuries. It is particularly important in any period of large-scale disaster. Unless the patient is disoriented, is in acute collapse, or is among the very small percentage who become nauseated by drinking large quantities of the salt solution, the sodium chloride formula will be effective when administered by mouth."

Dr. Scheele emphasized the fact that treatment by saline solution will in no sense decrease the need for whole blood. Rather, he pointed out, sodium chloride would provide an effective immediate form of treatment which could be administered by anyone.

"The recommendation of the Surgery Study Section, while of enormous benefit in the event of large-scale disaster, must not be construed as lessening in any way the importance of blood bank programs," he said. "Whole blood and plasma are still essential."

—*U.S. Federal Security Agency*

Hemolytic Disease

RUTH KELLEY

Average reading time — 3 min. 12 sec.

AS STUDENT NURSES we all have opportunities to assist in life-saving procedures but there are times, too, when we must stand helplessly by and see grim death advancing on our charges. It is gratifying to know that each year brings some new weapon with which to fight death and we student nurses owe a great deal to the persevering efforts of research workers. At this time I should like to pay special tribute to the doctors who did the pioneer work on the Rh factor because we had a striking example of the result of their efforts when we watched blood transfusions transform twin babies, who were born with hemolytic disease, commonly spoken of as Rh disease, from weak sickly infants to strong, robust babies.

The mother of those babies had given birth to twins some five years ago. Unfortunately, one of those first twins died during its first year of life. She became pregnant again and on her first prenatal visit was found to have Rh negative blood. Subsequent investigation revealed the fact that her husband had Rh positive blood and was homozygous, which indicated a strong likelihood of her child being born with hemolytic disease. She was watched carefully and it was discovered that this was again a twin pregnancy which fact increased the danger to her babies. Her titer at 30 weeks was free anti-C 1:1; at 36 weeks free anti-D 1:64 with blocking antibodies 1:16.

Preparations were made to have

the babies transfused immediately following birth. Through the Red Cross Blood Donor Service replacement transfusion sets were obtained, as was also the blood when it was called for. About two weeks before the expected date of confinement this mother was admitted to our obstetrical department at 7:00 p.m.—not the most desirable time. She went into labor and was delivered of twins, a male and female, about 1:00 a.m. At birth it was noted that the girl baby was very markedly pale with poor muscle tone. The boy baby was in better condition but was obviously affected also. They each weighed approximately six pounds. As their conditions were not considered critical at the moment it was decided to delay transfusing until morning when adequate laboratory work would be more easily available. In the morning specimens of blood taken at time of birth were examined in the laboratory and the correct blood group for each baby was established and blood supplied.

I had the privilege of being "scrub nurse" for this very important procedure and shall tell you about it just as it happened. Each baby was restrained on a circumcision board and placed on a sterile field. We used circumcision sheets for drapes just leaving the cords exposed. A large tank of oxygen was wheeled in and by means of a Y-tube and catheters each baby was given continuous oxygen during the procedure. Fine plastic catheters were threaded without difficulty into the umbilical veins. Using a 20-cc. syringe and a three-way stop-cock 20 cc. of blood were infused and 20 cc. withdrawn until in all 320

Miss Kelley was a senior student nurse at the Charlottetown Hospital, P.E.I., when she prepared this case study.

cc. were withdrawn and 360 cc. infused. A doctor was working with each child and the whole procedure was carried out in one and one-half hours. After each 100 cc. of infusion, 2 cc. of calcium gluconate were given to counteract any tendency to tetany caused by the citrated blood. My part was to cleanse the syringes, stop-cocks, and needles in normal saline and keep a clean set on hand for each doctor all the time. We had eight sets in circulation. I was busy!!

The babies experienced no discomfort whatsoever and did not even cry during the procedure. Their immediate conditions were excellent. The boy showed mild jaundice for a few days but became completely clear, fed well, showed adequate weight gain and was discharged with his mother on his eighth day. The girl, however, showed very marked

jaundice which gave way to extreme pallor. Her prognosis was somewhat guarded for a few days. Her hemoglobin dropped to 60 per cent and remained at that level for a week. She gradually showed signs of improvement; her hemoglobin increased until on discharge it was approximately 70 per cent. Her general condition was very good. She fed well, appeared bright and active and showed a weight gain better than average. She was discharged when two and one-half weeks old. It was felt that the 360 cc. of blood had not been adequate for the girl baby and her condition would have been much better had she been given 500 cc. However, both babies did very well and it was most gratifying to save them as subsequent pregnancies in this case will in all likelihood terminate in stillborn infants.

Book Reviews

Mental Hygiene in Public Health, by Paul V. Lemkau, M.D. 396 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Price \$5.45.

Reviewed by Alice Nicolle, Educational Supervisor, Ontario Division of Public Health Nursing.

Outstandingly practical and stimulating, Dr. Lemkau's book will be welcomed by the many public health nurses who are seeking to improve their understanding of mental hygiene.

Dr. Lemkau is an associate professor of Public Health Administration and director of Mental Hygiene Study in the School of Hygiene and Public Health, Johns Hopkins University. He has used his course in mental hygiene as a basis for the organization of his book which deals primarily with preventive measures and their application in the field of public health. Throughout this broad approach to both the need and the practicability of planning for mental hygiene services, it is

assumed that the prevention of maladjustment and mental disease is irrevocably tied up with efforts to prevent other conditions and diseases and as such is a public health responsibility. The author reminds us that "all preventive medicine has as its aim the avoidance of stress on the person at some level of his functioning."

The style of the book is direct and very readable. It is divided into two parts: Part I—The place of mental hygiene in public health; Part II—the development of the individual.

Only in an appendix, and very briefly, is "the classification of the psychopathological states" considered. This sets the book apart from most of the publications relating to mental hygiene. The apparent intention of this brief résumé is to keep before the reader the responsibility of public health workers for the early recognition of deviations from accepted behavior or adjustment and for an understanding cooperation with the psychiatrist.

In Part I, Dr. Lemkau deals with the change in attitude toward mental disease and its treatment, the interdependence of mental hygiene and public health practice, and the idea that methods used in both can be combined in the interest of the individual and his family. As in other diseases and their prevention, "the spread of interest in psychiatry has been from the patient in the institution to the functioning individual in the community."

A chapter is devoted to the discussion of the personality structure as it is affected by environment as well as heredity and the possible results of stresses and struggles on different types of personality. It includes the hopeful note that skilled and trained persons may assist the individual to withstand strain which is not too great and that even the less rugged personality may be helped to develop in spite of adverse conditions. A diagram of personality structure illustrates this theory.

The opportunities open to the generalized public health nurse are clearly recognized by the author—"a ready entry to a cross-section of homes in the community"—the fact that "she is closest to the people" and, therefore, in a strategic position both to recognize and to deal with situations (if she has the preparation) as well as to refer them when they are beyond her ability. Later, on page 193, the school nurse and physician are not so favorably commented upon.

For those interested in existing programs, *The Attack on the Problem* will provide many suggestions as well as material for comparison. Canadian and United States programs, both remedial and prophylactic, are described in some detail.

Part II of the book deals with an important aspect of mental hygiene of particular interest to the public health nurse. The development of the individual from conception to old age is treated as "a succession of epochs" rather than the usual age ranges, the dividing point being a developmental event such as walking or a sociological event such as beginning school. Each "epoch" is illustrated with everyday occurrences, their interpretation, and some methods of approach. The few individual or family studies are constructive.

A comprehensive bibliography at the end of each chapter and a final list of films relative to each part of the study complete a book which is an important addition to public health literature and deserves a place in every public health library.

How to Turn Ideas into Pictures—A simple method of illustrating publicity and educational materials, by H. E. Kleinschmidt, M.D. 31 pages. Published by National Publicity Council, 257-4th Ave., New York City 10. 1950. Price (in U.S.A.) \$1.00.

While some nurses have decided skill as artists most of us feel very inadequate when we try to sketch. We would all agree, however, that one picture may be more descriptive than a thousand words. This being so, the simple instructions, included in this little book, of how to use "visual shorthand" will open up a whole new avenue of approach to the average nurse. Dr. Kleinschmidt says: "Visual shorthand is not art nor drafting but merely a simple code for the transmission of ideas. Anyone who can write can develop the technique, modify it to suit his personality and his illustrating needs—and have fun."

This brief review would be read by everyone if we suddenly reverted to pictures. Maybe we should try! Order your copy and have some fun, too!



Sociology with Social Problems Applied to Nursing, by Sister Leo Marie Preher, O.P., B.A., Ph.D. and Sister M. Eucharista Calvey, O.S.F., R.N., B.A., M.S. 505 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Illustrated. Price \$4.40.

Reviewed by Peggy Pike, Instructor of Nurses, Allan Memorial Institute of Psychiatry, Montreal.

The authors divide this book into two parts—the first General Sociology and the second Sociologic Integration in the Field of Nursing. In so doing they attempt to show the close relationship of our environment to our total personality. As the result of this wider concept it is hoped that the nurse of

today will feel even more strongly that "the patient is a human being, of unique personality, and possessing human dignity."

Part I of the book follows the basic pattern of general sociology in a brief simplified form, as found in all sociology textbooks. However, the section on The Family is predominantly based on the Catholic way of life. The first half of this book should be read with a critical eye and used as a basis for discussion rather than a pure textbook.

Part II unites social problems and nursing. Much work has been put forth to provide statistics and charts to illustrate trends in community interest and the results thereof. The writers point out social handicaps of many diseases and follow with suggestions for the nurse in rehabilitating the patient, the family, and in contacting agencies.

This book is a valuable adjunct to a nursing library. However, the idealistic approach throughout must be tempered to the everyday needs and actions of society. At the close of each chapter there is an excellent list of suggested reading which in itself is outstanding.

Materia Medica for Nurses, by Lois Oakes, S.R.N., D.N. and Arnold Bennett, M.P.S. 373 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1949. Price \$2.25.

Reviewed by Sister Mary of Calvary, Director of Nurses, St. Martha's Hospital, Antigonish, N.S.

This book was written in a concise and simple manner so that the student nurse will have an adequate knowledge of the subject in order to intelligently administer the drugs prescribed. This edition presents the latest authentic information regarding the drugs covered. A good list of synonyms is to be found in the Appendix. Chapter XII, Poison Regulations, is very informative and complete. Another favorable point is the Dosage Calculation, which any instructor in this course should find very helpful.

Some important topics which, unfortunately, are omitted from this text are: drug addiction; toxicity and its treatment in connection with the sulfonamides; synthetic and artificial sources of drugs, as well as detail in reference to the action of drugs.

If the English as well as the Latin terms for drugs were given in the Posological Table (Chapter IV) it would be more meaningful.

The section on Common Drugs and Preparations, with their origin, action, and administration, is arranged in alphabetical order instead of in relation to the systems, as is generally found in texts on this subject. Such an arrangement increases the difficulty of presentation. The habit-forming tendency of the barbiturates and narcotics and the nurse's responsibility in this regard are not discussed. No mention is made of the contraindications for certain drugs to certain patients or under certain conditions.

This book merits recognition among the best reference texts but, because of the omission of valuable pertinent material, it cannot be recommended as a teaching text.

Hospital Administration for Women, by Emily MacManus. 349 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 2nd Ed. 1949. Price \$7.00.

Reviewed by A. L. Thomson, Director of Nursing, Civic Hospital, Peterborough, Ont.

The author is well qualified to write such a textbook from her wide experience and it should prove a valuable reference for any hospital administrator. It particularly deals with the operation of hospitals in Great Britain but there is invaluable material and information about nursing in other countries.

One point is stressed particularly which is worth much consideration on this side of the water and that is the diet peculiar to the different nationalities and its importance in the nursing care of the individual. This point is often overlooked.

At a time when most hospital personnel are on an eight-hour day and a 40- or 44-hour week, it is almost impossible to believe that nurses work as long hours as scheduled in some chapters.

Breakfast served in bed to nurses off duty brought forth a sigh of envy.

Nursing care and comfort of the patient are emphasized throughout the book.

Parkinson's Disease, by Walter Buchler. 79 pages. Published by Walter Buchler, 101 Leaside Cres., London, N.W. 11, Eng. 1950. Price \$1.00.

Success stories are not uncommon in current literature. However, when the venture in which the author has achieved success is in learning to live an interesting, vital, and productive life in spite of the affliction of



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paralysis agitans, it is of definite value to nurses.

Patients with advanced Parkinson's Disease, "P.D." as Mr. Buchler calls it, tend to become wholly dependent rather than seeking to develop their own personalities despite their affliction. Mr. Buchler has risen above the physical hindrances and his story of his achievement is offered as a guide to other P.D. patients. So he discusses the

ordinary details of living, eating, bathing, etc. He gives sound advice regarding intellectual exercise to keep the mind alert and active even though the body may be sluggish. Courage, resourcefulness, and activity characterize his attack.

This material gives a more exact picture of the disease than most texts. It will be informative for the nurse, helpful for her patients.

In Memoriam

Jane Lawrie Gray, who graduated in 1893 from the Hospital for Sick Children, Toronto, died on September 17, 1950, at the age of 86. Miss Gray had engaged in private nursing and for a time was on the staff of the Hospital for Incurables. She retired from active duty many years ago.

* * *

Pearl (Watson) Hamel, who graduated from Hotel Dieu, Windsor, Ont., in 1916, died suddenly in Monctonville, Ont., on September 12, 1950, at the age of 58. Mrs. Hamel served with the U.S. Army Nurse Corps during World War I, subsequently nursing in the United States until her marriage.

* * *

Cora M. Lloyd, who had administered a private hospital in Toronto for a great many years, died in Toronto on September 13, 1950. Born in Ontario, Miss Lloyd graduated from the Flushing (Long Island) General Hospital. She had retired last May.

* * *

Ethel Blanche (Christie) MacLaren, who graduated from McLean Hospital, Waverley, Mass., in 1898, died in Pictou, N.S., on September 20, 1950, after a long illness at the age of 74. Before her marriage, Mrs. MacLaren worked in the United States and in Pictou County.

* * *

Catherine Alice McQuillan, who graduated from St. Joseph's Hospital, Toronto, in 1929, died on September 13, 1950, at the age of 43, following an illness of two months. Miss McQuillan had engaged in private nursing for more than 20 years.

Stella (Ashfield) Shore, a graduate of St. Luke's General Hospital, Ottawa, died recently in Ottawa.

* * *

Dorothy Margaret Stewart, a graduate of the Vancouver General Hospital, died on September 30, 1950. For some time Miss Stewart was matron at Oakalla Prison Farm near Vancouver and later was superintendent at Prince George Hospital.

* * *

Harriet Thomson, who graduated from the Toronto General Hospital in 1895, died on September 19, 1950, in her 91st year. Miss Thomson had served for 35 years as a missionary in India under the auspices of the Presbyterian Church of Canada. She was superintendent of the Central India Mission Hospital for some years.

* * *

Edith (Gillies) Whitaker died on October 1, 1950, at her home in St. Catharines, Ont., in her 49th year. Mrs. Whitaker spent five years in India where her husband was the doctor at a leper colony.

—

If thou workest at that which is before thee, following right reason, seriously, calmly, vigorously, allowing nothing else to distract thee, but keeping thy divine part pure, as if thou shouldst be bound to give it back immediately; if thou holdest to this, fearing nothing, expecting nothing, but satisfied with thy present activity according to nature, and with heroic truth in every word and sound that thou utterest, thou shalt live happy, and there is no man can prevent it.

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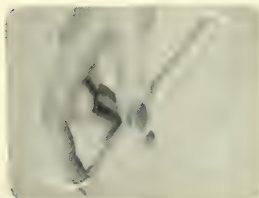
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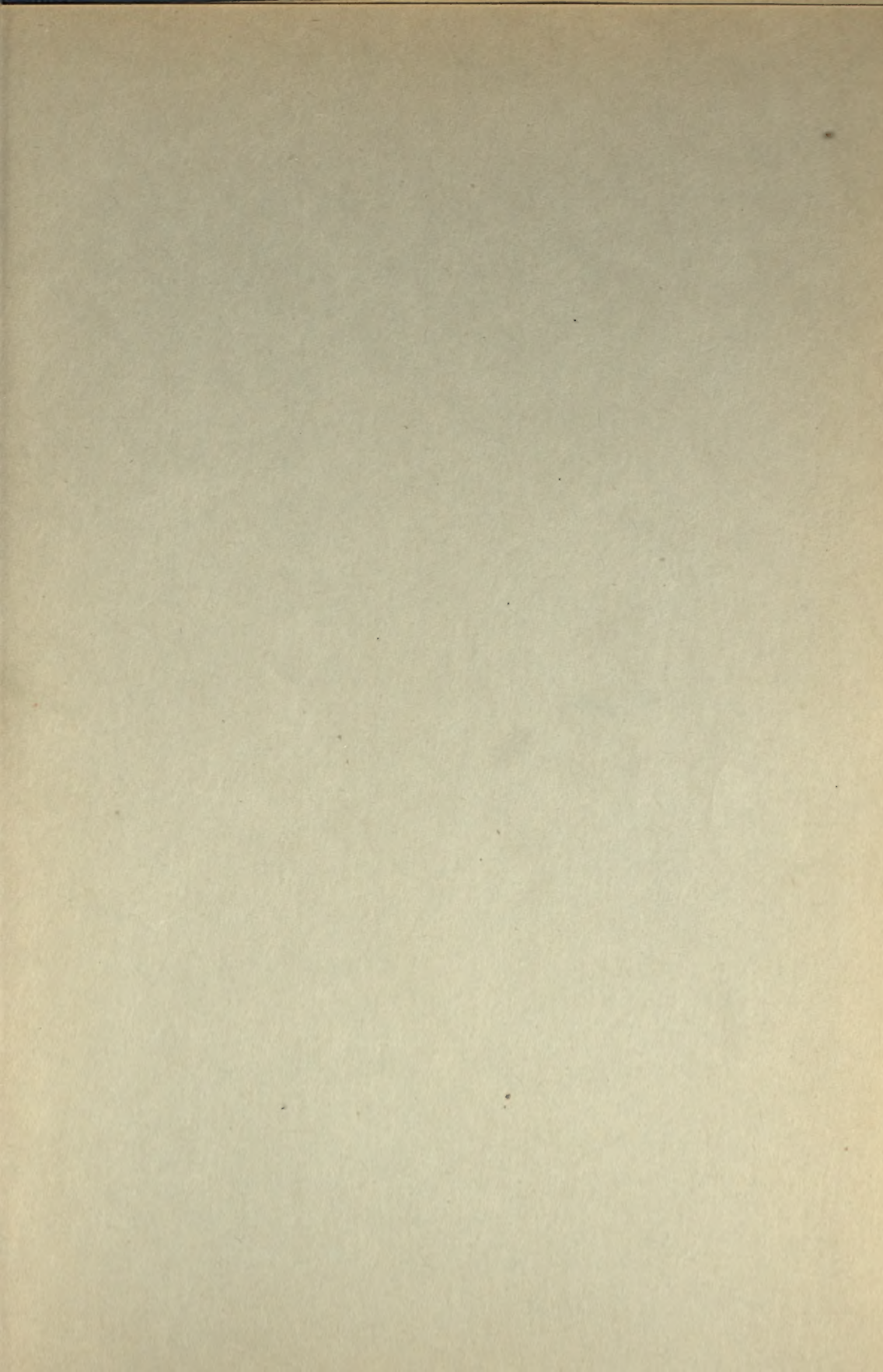


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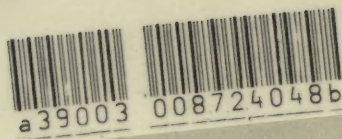
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